

**Aviation Safety Investigation Report
199502549**

**Bell Helicopter Co
JetRanger III**

10 August 1995

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Investigations commenced on or before 30 June 2003, including the publication of reports as a result of those investigations, are authorised by the Executive Director of the Bureau in accordance with Part 2A of the Air Navigation Act 1920.

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NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

The Bureau did not conduct an on scene investigation of this occurrence. The information presented below was obtained from information supplied to the Bureau.

Occurrence Number: 199502549

Occurrence Type: Accident

Location: Ayers Rock, Aerodrome

State: NT

Inv Category: 4

Date: Thursday 10 August 1995

Time: 1425 hours

Time Zone: CST

Highest Injury Level: Fatal

Injuries:

	Fatal	Serious	Minor	None	Total
Crew	0	0	0	1	1
Ground	0	0	0	0	0
Passenger	1	0	0	3	4
Total	1	0	0	4	5

Aircraft Manufacturer: Bell Helicopter Co

Aircraft Model: 206B (III)

Aircraft Registration: VH-FHX **Serial Number:** 2822

Type of Operation: Charter Passenger

Damage to Aircraft: Substantial

Departure Point: Ayers Rock NT

Departure Time:

Destination: Ayers Rock NT

Approved for Release: Tuesday, April 23, 1996

Four ladies had reservations for an helicopter scenic flight, and were met in the airport terminal by the ground hostess for transportation to the helipad in the company bus.

The ground hostess stated that while proceeding to the helipad she briefed the ladies about the helicopter, and the safety requirements when in its vicinity.

She parked the bus on the road adjacent to the helipad, approximately 12 metres to the right and well forward of the helicopter. The ladies were then told to remain at the bus until instructed to approach the helicopter.

Following normal practice to save engine cycles, and turn around times, the pilot left the helicopter engine running after landing, then locked the controls and got out to assist the ground hostess disembark the passengers, who were then directed to the bus. The ground hostess accompanied them as far as the edge of the main rotor disc, then signalled the ladies to follow her back to the helicopter.

One lady had expressed an interest to occupy the front left seat during the flight. This was agreed to by the other ladies.

The ground hostess watched the ladies follow her towards the helicopter, but when she turned her head to check its proximity, the lady, who had requested the front seat, left the group to pass behind the helicopter, and walked into the tail rotor, receiving fatal injuries.

The ground hostess stated that after the occurrence she spoke to the ladies, who confirmed that they had understood her briefings, and had no idea why the other lady had not followed her instructions.

Statements taken by the police did not address whether the ladies had received a safety, familiarisation briefing, but covered the last instructions given by the ground hostess concerning waiting at the bus, and approaching the helicopter. Only two of the ladies could now remember these instructions.

Reports indicated that three of the ladies were partially deaf, and the other had assisted them. Because of this it is possible they may have missed some parts of the briefing.

The company requires all staff to be aware of, and act in accordance with the requirements of the Civil Aviation Regulations and Orders, and the companies' Operations Manual, including all safety aspects. There was no evidence to indicate that the staff had not acted accordingly.

The reason why the lady departed from the group, and attempted to pass behind the helicopter was not established.