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Ref. - ASTO/CWC/CMD/Chopper Safety/22/2022 Date: 05.07.2022

To,
The CMD,
ONGC Ltd.

Sub: Accident Report and suggestions for corrective action.

Respected Madam,

Incident:

On 28th June 2022, a helicopter with call sign 'VT-PWI' operated by Pawan Hans Helicopters Limited (PHHL), with 07 Passengers on-board (06 ONGC & 01 Contractual) along with 02 pilots had taken off from Juhu Helibase around 1054 Hrs (IST) and was on final approach to ONGC Rig 'Sagar Kiran' but suddenly ditched at about 1141 Hrs. Four passengers were rescued from sea by OSV Malviya-16 while one passenger was picked-up by the Rig Sagar Kiran lifeboat. Three ONGC employees and one contractual employee were rescued by naval helicopters could not survive the crash.

We appreciate and salute the courage shown by on-board ONGC crew of the Rig 'Sagar Kiran' for putting their best effort by lowering life boat in adverse weather condition to rescue the passengers of ditched chopper and succeeded in saving one life.

Team ASTO Mumbai met with survivors of accident, interacted with offshore employees and concerned persons and would like to bring out the following issues that require immediate attention:

1. Chopper Model specific audio visual Safety briefing was not provided before boarding. It is a complete violation of SOP.
2. Safety briefing provided by Pawan Hans at Helibase is not up to the mark. It misleads the passenger by showing different methodology of operating safety equipment than the actual ones. It is a cause of concern that this has not been pointed out by people responsible from ONGC.
3. The passengers were not supported for properly wearing jackets at the time of boarding.
4. Lead passenger communication system was not in place. This is again violation of SOP. It seems that Pawan Hans does have a system for the same or do not check the same. Unfortunately people responsible from ONGC also do not check whether the services are as per the contract or not.
5. No communication/ alert was provided by Pilots to the passengers, which led to a lack of timely action at passenger's end for the placement of EBS or switching to brace position, failing the very purpose of HUET and putting lives in danger.
6. Chopper ditched into the sea near Rig Sagar Kiran in uncontrolled way with sudden thrust.

7. Chopper door released as soon as chopper touched the water.
8. The float of chopper got activated and the chopper capsized within seconds and all passengers including pilots came out from chopper.
9. Chopper life raft failed to launch which is a cause of concern as this led to worsening of the situation. The life raft could have given the passengers better chances of survival.
10. Most of the passengers couldn't open their life jacket on their own due to its typical and different inflating system from existing one as well as the ones used during trainings.
11. Life jackets which got inflated, were coming out from neck in the turbulent water due to large neck support size.
12. Survey Choppers deployed to locate passengers was directing more water towards the survivors and making it difficult for them to stay afloat amidst the thrust of the chopper and turbulence of the water.
13. Passengers including pilots who held on to the chopper appendages after coming out from chopper, could only survive except the one who was swimming little far from chopper and was picked up by Sagar Kiran life boat.
14. Non availability of dedicated Standby Boat during crew change of Rig Sagar Kiran led to some delay in emergency response. The dedicated boat is must as per safety standards.

These are some initial inputs received from the survivors. We therefore suggest following measures for immediate implementation:

1. Selection of chopper operator should be based on its experience and track record considering their company's operational stability as a factor.
2. Every Chopper should be inspected by an experienced rotor wing aviation expert before taking off from Helibase.
3. Strengthening existing training system with increased frequency.
4. All the HUET, SAS/RAS done during past years due to COVID via online system, to be mandatorily re-performed in physical settings. These trainings should have more practical sessions instead of theory sessions.
5. Mandatory swimming training sessions for 21 days, which used to be provided earlier, should be restored as one passenger whose life jacket failed to inflate could survive as he knew swimming.
6. Employees should be trained properly and thoroughly for all types of chopper operating for ONGC.
7. Monsoon Specific training module should be prepared and employees be trained to deal with emergencies during monsoon period.
8. Maintain uniformity of life Jackets and Re-Breather for all choppers. Use the same for training purpose also.
9. Introduction of user-friendly design of life Jackets and Re-Breather.
10. One on one briefing by main Pilot to all passengers before chopper boarding to be put in place.
11. Random testing of life Jackets and Re-Breather before boarding into chopper.

12. Pilots should be equipped with binoculars which will be useful to locate passengers form distance during search and rescue operation, and will also allow the chopper to maintain a safe distance from persons afloat in water.
13. Standby boat should be available during chopper landings at installations as per the safety standards. Following strict Chopper schedule will be helpful to provide standby boat at different locations.
14. Lead passenger system should always be in place and same should be tested before each take off.
15. OSV deployed for rescue should have net with two pulleys to catch the exhausted passengers from sea. Necessary modifications may be done in existing OSVs.
16. Chopper specific videos be prepared and shown compulsorily before boarding at Helibase as well as offshore installations.
17. Speed boat equipped with rescue system along with trained rescue team should be deployed in each offshore field.
18. Passengers and crew survivability equipment should have an integrated and certified Emergency Flotation System (EFS), Automatic Flotation Deployment System (AFDS), single action cabin door releases, large pop-out cabin windows and an Emergency Locator Transmitter (ELT).

Madam, presently employees are in a very demoralized state due to aforementioned incident and showing disinclination in reporting for offshore duty. It is high time to discuss the safety issues openly and take corrective action to initiate confidence building measures.

In view of emergent situation, your kind intervention is required to review the existing crew change operations by chopper for further strengthening it for incident free, smooth, and safe operations during helicopter journey to and from offshore.

Madam, it would be appropriate for a meeting of EC with ASTO CWC as per recent resolutions submitted to your good office along with aforementioned report to discuss the issues in detail and finalize actionable points so that things start changing at grass root level.

With Kind Regards,

Piyush Narain Pathak
Vice President,
ASTO-CWC

Mumbai Region: ASTO Office, ONGC LTD., 112, First Floor, Vasudhara Bhavan