

INCIDENT

Aircraft Type and Registration:	Agusta AW139, PH-EUJ
No & Type of Engines:	2 Pratt & Whitney Canada PT6C-67C turboshaft engine
Year of Manufacture:	2013 (Serial no: 31511)
Date & Time (UTC):	19 February 2017 at 0839 hrs
Location:	Leman 27B Platform, North Sea
Type of Flight:	Commercial Air Transport (Passenger)
Persons on Board:	Crew - 2 Passengers - 9
Injuries:	Crew - None Passengers - None
Nature of Damage:	None
Commander's Licence:	Airline Transport Pilot's Licence
Commander's Age:	41 years
Commander's Flying Experience:	8,000 hours (of which 2,975 were on type) Last 90 days - 105 hours Last 28 days - 43 hours
Information Source:	Aircraft Accident Report Form submitted by the pilot

Synopsis

Whilst planning for a seven-sector shuttle in support of a UK customer, the operations department mistakenly inserted the wrong helideck into the flight plan. The error was not noticed and the helicopter proceeded to land at the Leman 27B helideck instead of the Shell Leman 26B.

History of the flight

As part of ongoing collaboration between the Dutch and UK parts of the operator, the Dutch arm of the operator was tasked to provide support for a UK customer.

The flight was planned as a seven-sector shuttle. The flight plan was produced by the operations department at the crew base using information from the customer's planning system, which detailed the route and payload for each sector. This information was then used to generate an operational flight plan. During this manual planning process, the fourth planned destination was incorrectly selected as the Leman 27B, rather than Shell Leman 26B helideck.

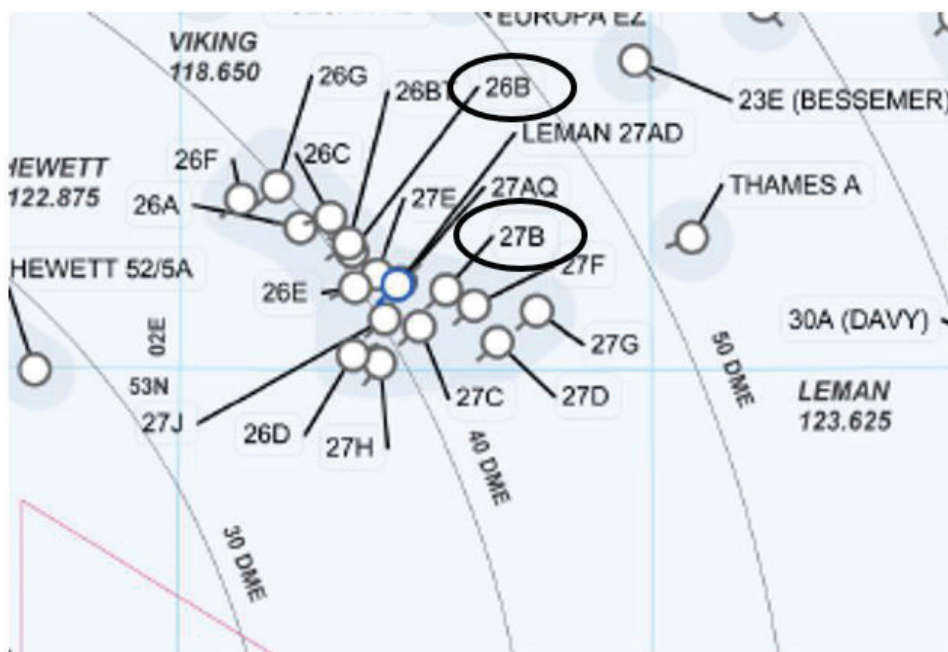


Figure 1

Rig map of Leman Field (Leman 27B is denoted as 27B, Shell Leman 26B as 26B)

The aircraft departed Den Helder Airport and the first three sectors were completed without incident. On the fourth sector the crew took off from the Seafox 4 platform to proceed to Leman 27B.

The crew landed on the Leman 27B helideck, which was unmanned because no helicopter arrivals were expected. The helicopter's passengers informed the crew that they had landed on the wrong rig and this was also confirmed by a radio call from Leman 27B. The crew correctly followed the company standard operating procedures for a landing on the wrong helideck. After consulting with the Leman area radio operator about the identity of the correct platform, the crew took off and proceeded to Shell Leman 26B where the helicopter landed without further incident.

Procedures

North Sea helicopter operators and their customers use a variety of different computer systems for flight planning, in aircraft flight management systems and monitoring the location of offshore workers. These systems use different sets of codes to denote helidecks. This means there is often a need to decode and re-code installations in order to transfer information between different systems.

The planned route generated by the customer was as follows:

DHR-K14C-L13D-SF4-LEB-LEG-LED-DHR

Operations staff at the crew base produced a flight plan on the basis of this route request which involved the selection of helidecks from a drop down menu. In this case, for the fourth sector, the operations staff entered the drop down menu using the name Leman when selecting for the code LEB, which brought up a list of Leman platforms from which Leman 27B was chosen. Leman 27B was the only installation in the list selected which ended in a B. In order for the flight plan to have shown the correct destination, they actually needed to enter the list with Shell, because LEB is the code for Shell Leman 26B. Entering the drop down list with Shell would have brought up the list which included Shell Leman 26B. The route was unfamiliar to operations staff in Den Helder because it was usually completed by the UK-based arm of the operator.

Once operations staff completed the flight plan, the information was available together with weather and payload information for the crew when they reported for their flight. The crew retrieved the route but were not required to check it against the customer's route request sheet. The plan was then digitally signed and downloaded onto tablets to be used for the flights. There was no clear information source for coding available to the crew at the time of the occurrence.

On arrival at Seafox 4 at the end of the 3rd flight, the crew were handed a manifest for their next flight. This manifest listed the passenger load as well as the destination which was written as 'Leman Bravo'.

Radio communications in the North Sea are advisory services to helicopters rather than air traffic control services. Each helicopter contacts the radio operator responsible for the area of the North Sea in which they are operating. This radio operator keeps a listening watch for the helicopter whilst it is in flight, and provides information on helideck states for installations where there are no helideck crews. In this case the Leman area radio operator was on the Seafox 4, and therefore was unable to see either the helicopter or the helidecks in the sector. The radio operator did advise the crew that the deck was clear but neither the crew nor the radio operator used the full callsign of the intended helideck.

Analysis

The job of entering the destinations into the flight planning software was made significantly more challenging due to the coding differences between the customer and the operator. The customer sheet detailing the passengers and helidecks listed the fourth destination as LEB, which operations staff mistakenly entered as Leman 27B.

This incident shows very close similarities to a serious incident involving AW139, G-VINB (Bulletin 07/2017). The incorrect installation was selected from a drop down menu and the mistake went unnoticed due to the complexities of coding differences. There was little chance for the crew to check the plan due to lack of information regarding the codes.

The use of 'Leman Bravo' on the manifest only served to reinforce the flight planning error in the minds of the crew. Neither the crew nor the radio operator used the full callsign of the intended destination when ascertaining helideck availability. This might have provided an

opportunity for the error to be picked up before the helicopter landed on the wrong helideck. The manifest check and the radio call were the last chances for the crew to prevent the mistake occurring.

Conclusion

An error at the flight planning stage led the crew to land on the wrong helideck. There were a number of occasions when the error could have been picked up: briefing before departure from Den Helder; crosschecking the flight plan and payload information before departing to the installation; and during the radio calls with the radio operator in the Leman area. Once the mistake was realised, the crew correctly followed the operator's procedures for landing on the wrong helideck before proceeding to the correct destination.

Safety actions

The operator carried out an internal investigation into the incident and identified a number of safety actions. These included a secondary check of flight plans to ensure that customer requirements and flight plans match, a review of flight planning for robustness and ease of use as well as a review of installation coding. The crew now have access to the coding information and are required to check their flight plans against the original customer request.