INCIDENT

Aircraft Type and Registration:	Agusta AW139, G-CIPW	
No & Type of Engines:	2 Pratt & Whitney Canada PT6C-67C turboshaft engines	
Year of Manufacture:	2013 (Serial no: 41344)	
Date & Time (UTC):	9 June 2017 at 1625 hrs	
Location:	Viscount Platform, North Sea	
Type of Flight:	Commercial Air Transport (Passenger)	
Persons on Board:	Crew - 2	Passengers - None
Injuries:	Crew - None	Passengers - N/A
Nature of Damage:	None	
Commander's Licence:	Airline Transport Pilot's Licence	
Commander's Age:	61 years	
Commander's Flying Experience:	13,840 hours (of which 444 were on type) Last 90 days - 70 hours Last 28 days - 24 hours	
Information Source:	Aircraft Accident Report Form submitted by the pilot plus operator's internal investigation and subsequent AAIB enquiries	

Synopsis

The crew approached and landed on what they mistakenly believed to be the correct offshore platform. However, the crew had not appreciated that the planned destination had been changed and, in part, this happened because certain platforms can be referred to using different identifiers. When the crew realised they had landed on the wrong, unmanned platform, they lifted off and continued to the correct platform without further incident.

An internal investigation by the helicopter operator recommended several actions which may be implemented to prevent such an incident recurring. This AAIB report also provides information concerning activities being undertaken across the offshore helicopter industry, by a trade association, to prevent Wrong Deck Landings (WDLs).

History of the flight

On the evening before the flight, the crew were e-mailed a schedule for the following day; to depart Norwich Airport at 1500 hrs for a charter flight to the Kelvin platform, LOGGS[1], the Viscount platform, then back to LOGGS before returning to Norwich. During the evening

Footnote

[1] LOGGS is the name for a complex of five interlinked platforms which are central to the Lincolnshire Offshore Gas Gathering System.

this route was input to the crew Flight Planning Software (FPS) by operations staff as '*NWI-KELVIN-LOGGS-VISCOUNT-LOGGS-NWI*', where NWI is the IATA code for Norwich Airport.

When the crew reported for work the next day, at 1200 hrs, the co-pilot was passed a paper '*Route Strip*' from the flight operations department which showed the details of the charter, including the expected payload for each sector. On this strip the routing appeared as '*NWI-KELVIN-LOGGS-OD-LOGGS-NWI*' but in the FPS the name '*VISCOUNT*' was still shown, rather than the helicopter operator coded identifier '*OD*'.

The co-pilot knew that the chartering company, which also operated the platforms, used different identifiers for certain platforms but he was not fully familiar with all of them and he assumed that '*OD*' was an alternative identifier for the Viscount platform. He therefore planned the flight on this basis and when he and the commander later discussed the task they referred to the routing in the FPS, which still showed '*VISCOUNT*' as one of their destinations. They were not informed that, after the chartering company first specified the Viscount platform (using its own identifying code of '*VO*') to the helicopter operator, it subsequently asked for this be changed to the Vampire platform, which it identified using the code '*OD*'.

The commander overlooked the paper strip and referred only to the route in the FPS, which was as he expected; including the sector to the Normally Unmanned Installation (NUI) known as Viscount, to pick up a group of workers who had been dropped off there earlier in the day by another helicopter crew. During their flight preparation, the pilots focussed attention on a forecast of thunderstorms, electing to carry extra fuel because of this.

After departing NWI, the pilots flew uneventfully to Kelvin and then to LOGGS with the commander as Pilot Flying (PF) while the co-pilot, acting as Pilot Monitoring (PM), was responsible for inputting the route into the Flight Management System (FMS). They departed LOGGS without any payload, so there was no need for them to be handed a manifest which would have noted the destination for any passengers or cargo. They informed the radio operator on LOGGS that they were lifting to go to Viscount but he did not identify the variance from the routing he was expecting, which was for them to go to the Vampire platform.

Inbound to Viscount, the PM radioed the Helicopter Landing Operator (HLO) who formed part of the team of workers waiting to be picked-up at Vampire. Because the HLO was using a portable radio, the pilots were not surprised that the received signal strength was weak and, despite asking the HLO to repeat his message, they were unable to hear the name of the platform. All they could distinguish was "…deck is available".

After completing their landing checks the crew confirmed the name painted on the platform was 'VISCOUNT' and then landed normally (Figure 1). Once on the helideck they realised there were no passengers for them and consequently they discovered they should have flown to the Vampire platform. They subsequently lifted from Viscount flew to Vampire and then completed the remainder of their task without further incident.

Figure 1

The Normally Unmanned Installation (NUI) known as Viscount

Commander's comments

Following the incident, the commander observed that on the '*Route Strips*', handed to pilots before a flight, some platforms tend to be referred to by the platform operator's identifier while some are referred to using an abbreviation of their name. This system has developed over a number of years and consequently Viscount appears on the strips as '*VISC*' but Vampire appears as '*OD*'. While the commander was conversant with this system, it occurred to him that his local knowledge was probably better than that of his co-pilot, who had only been based at NWI for a few months. The commander observed that this was the first time he had experienced a discrepancy between the strip supplied by flight operations and the FPS.

Despite the difficulty created by the different naming conventions, the commander stated that sufficient time was available for flight planning and he could have cross-checked the route shown on the strip against the route in the FPS. He also noted that he had been partially distracted by the forecast for thunderstorm activity and highlighted other contributory factors, which were later included in the helicopter operator's incident report. The co-pilot, in his role as PM, entered the route into the FMS, and this was the route the commander was expecting to see, so he readily accepted it.

Helicopter operator's investigation

Following an internal investigation the helicopter operator produced a report with a number of recommended safety actions which are being considered:

- The helicopter operator should liaise with the charterer (the platform operator) and agree an identification system for the various platforms. It was noted that the two platforms involved in this incident are in the process of being de-activated as the gas field in which they are located is expected to shut down in 2018.

- The helicopter operator should ensure that, before each takeoff, the charterer passes the crew a manifest for the next leg to be flown, even when no passengers or cargo are carried.

- The helicopter operator should eradicate the use of paper '*Route Strips*', by altering the practices used in its flight operations department and ensuring that updated route information received from the charterer is input directly to the FPS.

- The helicopter operator should liaise with the charterer to train HLOs so they only use agreed terminology and do not state a helideck is available until they believe the helicopter that has called them on the radio is making its final approach. It is appreciated that this may not be practical in poor weather, when a helicopter's on-board radar is used for approach guidance.

- An overview of the lessons learnt from this incident will be shared amongst all the helicopter operator's pilots.

CAA comment

The CAA noted that helicopters operating across the North Sea carry a paper '*Rig Map*' and at the time of the incident this showed the identifier '*VO*' as relating to the Viscount platform and '*OD*' to the Vampire. Use of this chart might have alerted the crew to the conflicting information they were given.

WDL prevention

Following several WDLs[2], one offshore helicopter operator commissioned a detailed study by a company with specialist knowledge of human performance in aviation. The study was later adopted by HeliOffshore, a global trade association for the offshore helicopter industry with over 100 member organisations[3], and the resulting report, dated 11 December 2015, identified 71 causal factors of WDLs and made 19 recommendations aimed at resolving the issue. This WDL report can be viewed by following a link from HeliOffshore's '*Resources*' web page.

Some of the WDL report's recommendations are relevant to this incident. Recommendation 4 suggests a focus on WDL risks during Crew Resource Management (CRM) training, while Recommendation 7 advocates the introduction of improved Threat and Error

Footnote

[2] The AAIB has investigated some of the WDLs recorded in UK waters in recent years. For example PH-EUJ in AAIB Bulletin 9/2017, G-VINB in AAIB Bulletin 7/2017, G-VINL and G-CHBY both in AAIB Bulletin 6/2016.

[3] HeliOffshore's website can be found at http://helioffshore.org/

Management (TEM) procedures, to help crews cope with the threat of mis-identifying their intended landing platform. Recommendation 9 advocates that routes allocated to crew be downloaded directly to the helicopter's FMS by the operator, thus eliminating the possibility of crews inputting an incorrect destination.

To help crews ensure they are making their final approach to the correct platform, Recommendations 13 and 14 suggest that, when possible, there should be a radio exchange with the HLO (or equivalent) who should, in most instances, be able to see there is a helicopter close to the platform before indicating the helideck is available. The most relevant recommendation to this incident (and also to the one involving PH-EUJ mentioned at Footnote 2), is for the industry and its regulators to introduce an agreed protocol for offshore platform identifying codes.

In May 2016, in response to the WDL report, HeliOffshore, in collaboration with the International Association of Oil and Gas Producers (IOGP) wrote to regulators, original equipment manufacturers, operators, industry associations and providers of navigational databases and asked for action to be taken by specific organisations to tackle particular recommendations. HeliOffshore's '*Operational Effectiveness Workstream*' is currently liaising with these industry partners to progress the actions recommended.

While work continues to try to implement each of the WDL report's recommendations, HeliOffshore has recently published a guide aimed at formalising industry best practice for offshore approaches[4]. Incorporated within some of the guide's concepts are procedures associated with the WDL report's recommendations.

Conclusion

The crew of this helicopter proceeded to the wrong offshore platform because the operator's flight planning system had not been updated to reflect a change of destination and because different platform identifiers were used by the operator and the chartering company.

Safety Actions by the helicopter operator are aimed at preventing a similar incident from occurring, while the trade organisation HeliOffshore is promoting a global system of identifying codes for offshore platforms. This move by HeliOffshore is one of many safety initiatives it is taking and the publication of this AAIB report provides the industry with an insight to efforts being made to prevent Wrong Deck Landings.

Bulletin Correction

The printed December Bulletin incorrectly states that this **Incident** was classified as a Serious Incident. A Bulletin Correction will be circulated at the earliest opportunity.

Footnote

[4] The guide can be downloaded at http://helioffshore.org/wp-content/uploads/2016/07/Approach-Management-Guidelines-v2.pdf