

Air Accidents Investigation Branch

Accident Report No: **7/2008** **(EW/C2006/12/03)**

Operator: CHC Scotia Limited

Aircraft Type and Model: Aerospatiale SA365N, Dauphin 2

Manufacturer's Serial No: 6114

Nationality: British

Registration: G-BLUN

Location: Approximately 450 metres south-south-east of the
North Morecambe gas platform, Morecambe Bay,
Irish Sea
Latitude N 53° 57.361'
Longitude W 003° 40.198'

Date and Time: 27 December 2006 at approximately 1833 hrs

All times in this report are UTC (coincident with
local time)

Synopsis

The London Air Traffic Control Centre notified the Air Accidents Investigation Branch of the accident at 1906 hrs on 27 December 2006; the investigation commenced the next day. The following Inspectors participated in the investigation:

Mr R Tydeman	Investigator-in-Charge
Mr M Cook	Operations
Mr K Conradi	Operations
Mr M Jarvis	Engineering
Mr S Moss	Engineering
Mr P Wivell	Flight Data Recorders
Mr A Burrows	Flight Data Recorders

The helicopter departed Blackpool at 1800 hrs on a scheduled flight consisting of eight sectors within the Morecambe Bay gas field. The first two sectors were completed without incident but, when preparing to land on the North Morecambe platform, in the

dark, the helicopter flew past the platform and struck the surface of the sea. The fuselage disintegrated on impact and the majority of the structure sank. Two fast response craft from a multipurpose standby vessel, which was on position close to the platform, arrived at the scene of the accident 16 minutes later. There were no survivors amongst the five passengers or two crew.

The investigation identified the following contributory factors:

- 1 The co-pilot was flying an approach to the North Morecambe platform at night, in poor weather conditions, when he lost control of the helicopter and requested assistance from the commander. The transfer of control was not precise and the commander did not take control until approximately four seconds after the initial request for help. The commander's initial actions to recover the helicopter were correct but the helicopter subsequently descended into the sea.
- 2 The approach profile flown by the co-pilot suggests a problem in assessing the correct approach descent angle, probably, as identified in trials by the CAA, because of the limited visual cues available to him.
- 3 An appropriate synthetic training device for the SA365N was available but it was not used; the extensive benefits of conducting training and checking in such an environment were therefore missed.

Six Safety Recommendations have been made.