

## IMCA Safety Flash 09/16

April 2016

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat ([imca@imca-int.com](mailto:imca@imca-int.com)) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at [www.imca-int.com/links](http://www.imca-int.com/links). Additional links should be submitted to [webmaster@imca-int.com](mailto:webmaster@imca-int.com)

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

### 1 August 2013 Super Puma Helicopter Crash

The UK Air Accident Investigation Branch (AAIB) has published a report into the fatal accident to Eurocopter AS332 L2 Super Puma, call-sign G-WNSB, on its approach to Sumburgh Airport in the Shetland Islands on 23 August 2013.

At 17:17 hrs UTC on 23 August 2013, an AS332 L2 Super Puma helicopter with 16 passengers and two crew on board crashed into the sea during an approach to land at Sumburgh Airport. Four of the passengers did not survive. The flight was transporting employees of the UK offshore oil and gas industry back to Aberdeen, and was calling at Sumburgh Airport to refuel.

The AAIB investigation identified the following causal factors in the accident:

- ♦ The helicopter's flight instruments were not monitored effectively during the latter stages of the non-precision instrument approach. This allowed the helicopter to enter a critically low energy state, from which recovery was not possible;
- ♦ Visual references had not been acquired by the Minimum Descent Altitude (MDA) and no effective action was taken to level the helicopter, as required by the operator's procedure for an instrument approach.

The following contributory factors were identified:

- ♦ The operator's standard operating procedure (SOP) for this type of approach was not clearly defined and the pilots had not developed a shared, unambiguous understanding of how the approach was to be flown;
- ♦ The operator's SOP at the time did not optimise the use of the helicopter's automated systems during a Non-Precision Approach;
- ♦ The decision to fly a 3-axes with V/S mode, decelerating approach in marginal weather conditions did not make optimum use of the helicopter's automated systems and required closer monitoring of the instruments by the crew;
- ♦ Despite the poorer than forecast weather conditions at Sumburgh Airport, the commander had not altered his expectation of being able to land from a Non-Precision Approach.

A comprehensive report is available here: [www.gov.uk/aaib-reports/aircraft-accident-report-aar-1-2016-g-wnsb-23-august-2013](http://www.gov.uk/aaib-reports/aircraft-accident-report-aar-1-2016-g-wnsb-23-august-2013)