

# In-flight Depressurization

**Cargo door seal was installed incorrectly.**

BY MARK LACAGNINA

The following information provides an awareness of problems in the hope that they can be avoided in the future. The information is based on final reports by official investigative authorities on aircraft accidents and incidents.



## JETS

### Crew Conducts Emergency Descent

Airbus A330-300. No damage. No injuries.

Soon after departing from Dublin, Ireland, at 1241 local time on Aug. 18, 2005, for a flight to Shannon International Airport, the flight crew observed an “ENG 1 BLEED LOW TEMP” warning on the electronic centralized aircraft monitor (ECAM). “The ECAM actions were carried out, but the indication remained,” said the report by the Irish Air Accident Investigation Unit (AAIU).

As the aircraft climbed through 10,000 ft, the captain noticed that cabin altitude was an unusually high 4,900 ft. He decided to continue the flight at 10,000 ft rather than climb to 16,000 ft, as planned. The aircraft was landed without further incident at 1317.

A postflight report (PFR) generated by the aircraft maintenance computer indicated a no. 1 engine bleed problem and a cross-bleed problem. “There was no reference on the PFR to a pressurization problem,” the AAIU report said. A test of the bleed management computer for the no. 1 engine revealed a fault that subsequently had been cleared. Nevertheless, the bleed management computer was replaced. After the engine bleed, cross-bleed and

pressurization systems were checked by engineers, the aircraft was released for service. “The engine bleed and pressurization systems were again checked by the flight crew, and all indications were normal, with the aircraft pressurizing normally,” the report said.

The aircraft then departed from Shannon, at an unspecified time, with 237 occupants for a scheduled flight to New York. While climbing to cruise altitude, the crew observed cabin altitude increasing through 7,500 ft and reduced the rate of climb. As the aircraft was being leveled at Flight Level (FL) 350 (approximately 35,000 ft) over the Atlantic Ocean, cabin altitude increased through 8,500 ft. The crew changed the pressurization mode from automatic to manual but were unable to control cabin altitude. At about 1515, they requested and received clearance from air traffic control (ATC) to descend and return to Shannon.

Cabin pressure then increased to nearly 10,000 ft, and an ECAM warning was generated. The crew donned their oxygen masks, declared PAN and conducted an emergency descent to 10,000 ft. “On completion of the checklists, the flight crew conducted a full [analysis] of the situation and, having considered all options, including burning off fuel, etc., decided to prepare for an overweight landing at Shannon and to land as soon as possible,” the report said.

The crew requested and received vectors from ATC for a long final approach to Runway 24, and landed the aircraft uneventfully at 1623. “Neither the passengers nor the crew reported any ill effects,” the report said.

**The door seal had been installed “inside out and upside down.”**

Engineers visually inspected the cabin pressure outflow valve and found no abnormalities. Then they inspected the aft cargo door seal, which had been replaced two days before the incident flight by the airline’s maintenance contractor in Dublin. The report said they found that the door seal had been installed “inside out and upside down,” preventing inflation of the seal by pressurized air in the cargo hold. Pressurized air normally enters through 2-mm (0.1-in) holes in one side of the seal; because of the incorrect installation of the seal in the incident aircraft, the holes faced the outside of the aircraft. This resulted in a pressurization leak through the unsealed cargo door.

### Windshield Emits Smoke and Flames

Bombardier CRJ200. Minor damage. No injuries.

The aircraft was climbing through 17,000 ft after departing from Asheville, North Carolina, U.S., for a scheduled flight with 30 passengers to Covington, Kentucky, on March 19, 2006, when the captain smelled smoke. “A few seconds later, flames and smoke started shooting out of the lower left [side of the] windshield,” said the U.S. National Transportation Safety Board (NTSB) report.

The captain told the first officer to turn off the windshield heating system. This eliminated the flames, but the smoke persisted. The crew declared an emergency and returned to Asheville Regional Airport, where the aircraft was landed without further incident.

Postflight examination of the aircraft revealed overheat damage to the windshield near a terminal block for the windshield heating system. “The overheat damage was the result of an improperly installed fastener that resulted in arcing between the terminal block lug, the aircraft wiring eyelet, and the fastener and lock washer that secure the two components together,” the report said. “The arcing progressed over time, degrading the solder junction between the terminal block and the windshield heating system braid wire [and resulting] in heat damage to the sealant and the subsequent flame.”

### Catering Vehicle Struck During Pushback

Boeing 737-700. Substantial damage. No injuries.

The aircraft was being prepared for departure from Chicago for a scheduled flight with 105 passengers to Tampa, Florida, U.S., the morning of July 8, 2005. The driver of a catering vehicle that had serviced the 737’s aft galley was awaiting marshalling assistance to back the vehicle away from the aircraft, the NTSB report said.

The driver of another catering vehicle parked behind the aircraft and exited the vehicle to assist the driver who had serviced the 737. He then returned to the vehicle and prepared to drive it away from the aircraft.

Meanwhile, however, the operator of the pushback vehicle, who was not aware of the catering vehicle behind the aircraft and who had not received the “clear for pushback” signal from the aircraft marshaller (wing walker), began the pushback. The marshaller, who was in sight of the pushback vehicle operator, gave the hand signal to stop the pushback. “I put up the stop signal and yelled ‘stop,’ but the plane kept on being pushed,” he said.

The section of the aircraft near the auxiliary power unit (APU) door struck the catering vehicle and tipped it over onto its side; the driver was not injured. The flight crew said that they “did not feel any jolts or unusual aircraft movement” when the impact occurred. However, after noticing that the APU had stopped operating, they discontinued the engine-start procedure and halted the pushback.

NTSB said that the probable cause of the accident was “the pushback tow driver not maintaining visual lookout for the wing walker’s visual signal.”

### No Explanation for Cockpit Blackout

British Aerospace BAe 146-300. No damage. No injuries.

The aircraft was en route from London to Inverness, Scotland, with 71 passengers aboard on the night of Nov. 8, 2006. Soon after the APU was started during descent, there was a loss of electrical power to the primary flight displays, navigation displays and cockpit

lighting, said the U.K. Air Accidents Investigation Branch (AAIB) report.

The flight crew declared an emergency and reported the situation to ATC. They flew the aircraft in visual meteorological conditions (VMC) above the clouds while troubleshooting the problem.

“The commander ‘worked backwards’ and switched the APU off,” the report said. “Generator 1 (GEN 1) and Generator 4 (GEN 4) were then reset, and electrical power to all the flight deck displays returned to normal.” The cabin crew reported that galley power had been lost momentarily but the cabin lights had remained illuminated. “At no stage were any circuit breakers found to be tripped,” the report said.

The flight crew conducted an instrument landing system (ILS) approach and landed without further incident at Inverness. “On the ground, the only fault which could be identified was a possible problem on the ground service bus,” the report said. Replacement of the no. 1 generator control unit eliminated the problem. “The aircraft was returned to service, from which time it has continued to operate without any recurrence,” the report said. The AAIB and the aircraft manufacturer were unable to determine conclusively what caused the loss of electrical power.

### Smoke Enters Flight Deck — Twice

Avro 146 RJ100. Substantial damage. No injuries.

The aircraft was descending to land at Edinburgh, Scotland, the night of Sept. 20, 2006, when smoke began to fill the flight deck. The crew observed low oil pressure in the no. 2 engine and shut down the engine, the AAIB report said.

After the Avro was landed and the 51 passengers were deplaned, the aircraft was ferried to the airline’s maintenance base in Birmingham, England, where the no. 2 engine was replaced. During departure, smoke again filled the flight deck after the flight crew shut down the APU and selected engine air. “Engine air was quickly turned off and APU air selected,” the report said. “The APU was then restarted, and, as the APU air entered the aircraft, the smoke

started to clear very rapidly.” The crew returned to Birmingham and landed without further incident.

“It was concluded that, on the first occasion, a bearing failure led to seal damage and contamination of the air conditioning system,” the report said. “It appeared that residual oil in the system, resulting from the initial failure, had not been eliminated during the rectification and was responsible for the second event.”

### Aluminum Plate Strikes Tail During Taxi

Boeing 737-300. Substantial damage. No injuries.

The airplane was being taxied for departure from La Guardia Airport in New York on June 8, 2006, when the right horizontal stabilizer was struck by an aluminum plate. The NTSB report said that the plate, which measured 25 in by 60 in (64 cm by 152 cm) had been left on the taxiway by workers performing taxiway maintenance.

“The plate was supposed to have been a thicker and, hence, heavier steel plate to prevent it from being affected by the jet blast from taxiing airplanes,” the report said. “Guidance to the construction company regarding the use of such plates was provided by the FAA [U.S. Federal Aviation Administration] and the airport authority.”

### Controller Error Blamed for Incursion

Airbus A330-300, Boeing 737-300. No damage. No injuries.

Operations on intersecting runways were being conducted in VMC at Boston Logan International Airport the afternoon of June 9, 2005. The local east controller (LCE) was responsible for operations on Runway 04R and Runway 09, and the local west controller (LCW) was responsible for operations on Runway 04L and Runway 15R, the NTSB report said. Runways 04L and 04R were being used for landings, and Runways 09 and 15R were being used for departures.

Because Runway 15R intersects the other three runways, the LCW was required to receive a release from the LCE before clearing an aircraft to take off on Runway 15R. After providing a release, the LCE was required to

**“As the APU air entered the aircraft, the smoke started to clear very rapidly.”**

cease operations on the other runways until the aircraft departed from Runway 15R.

The LCW received a release from the LCE before clearing the Airbus, which had 340 people aboard, for takeoff on Runway 15R. Five seconds later, the LCE cleared the Boeing, which had 108 people aboard, for takeoff on Runway 09. The 737 first officer said that he had just called “V<sub>1</sub>” when he saw the A330 rotating near the intersection. “He told the captain to ‘keep it down’ and pushed the control column forward,” the report said. “He further stated: ‘The Airbus passed overhead our aircraft with very little separation, and once clear of the intersection, the captain rotated, and we lifted off towards the end of the runway. I reported to departure control that we had a near miss, at which time [a flight crewmember aboard the A330] reported, ‘We concur.’”

The LCE told investigators that he had been very busy and had forgotten that he had given the LCW a release for the A330’s departure. NTSB said that the probable cause of the runway incursion was the LCE’s failure to follow standard operating procedures.

### Engine Surges Involved in Control Loss

Gates Learjet 35. Substantial damage. No injuries.

Nighttime VMC prevailed on March 22, 2006, when the flight crew began a “standing-start” takeoff from Runway 27L at Philadelphia International Airport for a cargo flight. The pilot held the wheel brakes until the engines spooled up to 70 percent N<sub>2</sub>, high-pressure rotor speed, then released the brakes and increased power.

The NTSB report said that the pilot disengaged the nosewheel steering system when the copilot called out “airspeed alive” at about 60 kt. Airspeed was about 95 kt when the airplane began to turn right. “The copilot noticed fluctuations with the engine indications and called for an abort,” the report said. “The pilot reduced the power to idle and corrected back to the left using left rudder pedal and light braking. The airplane then turned to the right again, and the pilot corrected once again to the left. The airplane continued to turn left and departed the left side of the runway, tail-first, at a 45-degree

angle.” The right main landing gear collapsed, and the right wing-tip tank struck the ground before the Learjet was stopped.

NTSB said that surging of the left engine during takeoff and the flight crew’s subsequent loss of control of the airplane resulted from the operator’s inadequate maintenance of the engine’s fuel computer harness. Company maintenance records indicated that the harness had been checked six days before the accident. However, investigators found several discrepancies, including deteriorated and missing shielding, corrosion, a worn ground wire and a broken connector pin.

## TURBOPROPS

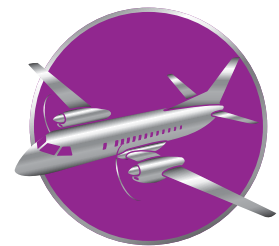
### Barrel Roll During Missed Approach

Beech King Air A90. Destroyed. No injuries.

Daytime instrument meteorological conditions prevailed on Aug. 22, 2006, when the pilot flew his King Air from Weston, Ireland, to Knock to practice instrument approaches and gain familiarity with an integrated avionics system that had been installed in the airplane. The pilot had 743 flight hours, including 95 flight hours in type. His passenger had about 2,000 flight hours in multiengine airplanes, had previously owned a King Air and was familiar with the avionics system.

The AAIU report said that weather conditions worsened as the airplane neared Knock. Visibility was 4,400 m (2 3/4 mi) with light rain, and ceilings were broken at 100 ft and overcast at 500 ft. ATC cleared the pilot to conduct an ILS approach to Runway 27. The pilot told the controller that he would discontinue the approach 600 to 700 ft above the airport and go around for another approach. The controller told the pilot to initiate the missed approach with a right turn and climb to 3,000 ft while navigating directly to the initial approach fix.

The pilot hand-flew the ILS approach to 1,400 ft, about 735 ft above the airport, and began the missed approach. He said that he retracted the landing gear, partially retracted the flaps and was climbing straight out at about 140 kt when he felt a sudden jolt and the aircraft



rolled right, beyond 90 degrees of bank, and did not respond to aileron input. “He said that he did not believe he had become distracted and that he was very conscious of what he was doing,” the report said. “The [passenger] joined [the pilot] on the controls during the upset, and he let him take control, as [the passenger] was a much more experienced pilot.”

The passenger said that he had been examining a chart when he glanced up and noticed the excessive bank angle; he did not feel a jolt or any significant turbulence. He said that application of left aileron had little effect, and he decided to continue the right roll. “Due to his position in the cockpit, he was unable to reach the throttles, which were at a high power setting,” the report said. “As the aircraft rolled inverted ... he could see the roof of the canopy getting darker as they neared the ground. He continued the roll until brightness showed in the canopy again, applying full back pressure to the controls.” The passenger said that during recovery, airspeed increased to between 280 and 300 kt, and aerodynamic loading reached about 5 g.

The King Air was flown back to Weston and landed without further incident. The pilot said that he did not see anything wrong with the aircraft and was surprised when his mechanic later told him about the damage, which included buckled skin on the wings and empennage. The report said that the underlying structural damage likely was beyond economic repair.

### Weather Below Approach Minimums

Swearingen Merlin. Destroyed. One fatality, four minor injuries.

The pilot was conducting a private flight from Beaumont, Texas, U.S., to Craig Airport in Jacksonville, Florida, the morning of Nov. 27, 2003. His four children were aboard as passengers. The pilot knew before departure that weather conditions were below the approach minimums at Craig Airport and, nearing Florida, was told by an air traffic controller that the fog at the airport was not expected to lift for at least an hour and a half, the NTSB report said.

The pilot also learned that the airport in nearby St. Augustine was reporting clear skies

and 2 mi (3,200 m) visibility, and that aircraft were landing at Jacksonville International Airport, which had a runway visual range (RVR) greater than 6,000 ft (1,800 m). The pilot told ATC that he would “take a look at Craig” and that he had the current automatic terminal information service information, which included a vertical visibility of 100 ft and 1/4 mi (400 m) horizontal visibility. He requested and received vectors for the ILS approach to Runway 32, which had a decision height of 241 ft and a minimum visibility of 1/2 mi (800 m).

Recorded ATC radar data indicated that the Merlin descended below the ILS glideslope during final approach. The airplane struck trees, rolled right and struck the ground 1.8 nm (3.3 km) from the airport at 0752 local time. The pilot was killed; the passengers received minor injuries.

### Power Loss Traced to Gearbox Malfunction

British Aerospace Jetstream 32. Substantial damage. No injuries.

The aircraft was on a scheduled passenger flight from Mount Gambier, South Australia, to Adelaide the afternoon of Dec. 23, 2005. During a shallow turn at FL 120, about 93 km (50 nm) east of Adelaide, the right engine surged twice and then stopped, said the report by the Australian Transport Safety Bureau (ATSB).

The flight crew secured the engine and requested and received clearance from ATC to fly directly to Adelaide and to descend to 10,000 ft. Before beginning the descent, the crew attempted an automatic and a manual restart. “During these attempts, the engine would rotate and the propeller would unfeather, but the engine would not start,” the report said. The crew conducted a single-engine landing without further incident.

Examination of the engine revealed two damaged gears in the propeller reduction gearbox. A tooth on one gear was fractured, and several others were worn; all the teeth on the gear to which it mated were missing.

The report said that the operator had purchased the engine from the manufacturer and installed it on the Jetstream on Dec. 20, 2005. The gear with the lesser damage had been installed

“The engine would rotate and the propeller would unfeather, but the engine would not start.”

new by the manufacturer during a continuing airworthiness maintenance inspection in October 2005; the gear with the stripped teeth had been in the gearbox since the engine was manufactured. The engine had accumulated 6,258 operating hours since manufacture, including 16 operating hours since its installation on the Jetstream.

ATSB said that accelerated tooth wear on the more extensively damaged gear likely resulted from “the mating of new and worn components,” but it could have been initiated by a foreign object in the gearbox.



## PISTON AIRPLANES

### Hypoxia Likely Caused Control Loss

Cessna 404. No damage. No injuries.

The unpressurized aircraft departed from San Pedro Airport, Cape Verde Islands, at 1855 local time for a private flight to Dakar, Senegal, on Dec. 16, 2006. The U.K. AAIB report said that the pilot did not continuously use supplemental oxygen above 10,000 ft during the climb to, and initial cruise at, FL 210. The passenger said that the pilot took off his oxygen mask several times. The pilot told investigators that he took off his oxygen mask to respond to a perceived engine problem at about 1930.

“He was probably suffering from hypoxia when he attempted to adjust his engine controls, and this resulted in vibration and an uncontrolled descent,” the report said. The passenger said that he heard a change in engine noise and felt the vibration before the aircraft began to descend at high speed and in a spiral. He called the pilot twice on the intercom system. The aircraft was descending through 5,000 ft when the pilot responded to the passenger’s second call.

After regaining control of the airplane, the pilot requested and received clearance from ATC to divert to Amilcar Cabral Airport, Cape Verde Islands. He landed there without further incident at 2005. The pilot said that he likely began experiencing hypoxia during the climb and that the perceived engine problem probably had resulted from the engine controls being improperly set for cruise flight.

### Cannabis Consumption Noted in CFIT Probe

Piper Seneca II. Destroyed. Three fatalities.

The airplane was chartered for a sightseeing flight from Ardmore to Kerikeri to Taupo, on New Zealand’s North Island, the morning of Feb. 2, 2005. Although the operator told the two passengers that weather conditions were not good, they elected to take the flight as planned, said the report by the New Zealand Transport Accident Investigation Commission.

The pilot conducted two instrument approaches to Kerikeri but was unable to land because of the weather conditions. He requested and received clearance from ATC to proceed to Taupo, which was reporting 50 km (31 mi) visibility and a broken ceiling at 4,000 ft. Before the pilot began the descent, the controller asked which instrument approach procedure he intended to fly. The pilot said that he would conduct the NDB/DME (nondirectional beacon/distance measuring equipment) approach.

Before beginning the approach, the pilot was told by an airport Unicom operator that the weather was “closing in a bit.” Visibility was 7,000 m (4 mi), and there were a few clouds at 1,000 ft and a broken ceiling at 2,000 ft. The minimum descent altitude for the circling approach was 1,940 ft, and minimum visibility was 2,800 m (1 3/4 mi).

After turning inbound, the aircraft’s ground track deviated increasingly left of the intermediate and final approach tracks. When the pilot reported crossing the final approach fix — his last radio transmission — the Seneca was about 6 km (3 nm) left of the fix. The aircraft was at 2,600 ft about 30 seconds later when it struck a mountain 8 km (4 nm) from the airport.

Investigators found no anomalies with the navigation aids, and no likely sources of signal interference were identified. “No obvious cause for the accident could be determined,” the report said. “Autopsy reports showed the pilot had consumed cannabis [marijuana], probably between 12 and 24 hours before the accident. While cannabis can adversely affect a person’s ability to operate an aircraft, its effects can vary greatly; so, this could not be conclusively identified as a cause of this accident.”



## Icing Triggers Stall on Departure

Cessna T310R. Destroyed. One fatality.

Moderate icing conditions prevailed on the pilot's normally scheduled cargo route in Arizona, U.S., on Dec. 7, 2004. The pilot landed in Flagstaff, which had 1 1/2 mi (2,400 m) visibility and a 300-ft overcast, at 1826 local time and requested that the airplane be deiced. The line service technician who deiced the 310 said that there was a substantial amount of ice on the airplane and that light snow continued to fall at the airport until the airplane departed more than an hour later.

Witnesses said that the airplane rotated about 5,000 ft (1,524 m) down the 7,000-ft (2,134-m) runway and that one or both of the engines sounded very rough. The airplane was descending in a wings-level and slightly nose-high attitude when it struck a highway embankment 2 nm (4 km) from the airport. Elevation of the accident site was 6,798 ft — 200 ft lower than airport elevation.

The NTSB report said that the operator kept a truck on standby at the airport to transport the cargo if it could not be flown because of weather conditions or a mechanical problem. However, entries in the pilot's journal indicated that he perceived considerable pressure to operate the 310, which did not have deicing boots, in icing conditions. "There was insufficient information from which to determine whether the company culture condoned or encouraged this behavior," the report said.

NTSB said that the probable cause of the accident was the pilot's decision to attempt flight in known adverse weather conditions and with ice and snow that had accumulated on the airplane while it was on the ground.

## HELICOPTERS

### External Line Strikes Tail Rotor

Messerschmitt-Bolkow-Blohm BO 105. Destroyed. One serious injury.

After completing 27 cargo flights from a coast guard vessel to a lighthouse in Bella Bella, British Columbia, Canada, on May

7, 2005, the helicopter was returning to the ship with less than 40 kg (88 lb) of gear in the bonnet (sling). The bonnet, which was attached to the helicopter by a 33-m (108-ft) external line, had been lashed closed with a polypropylene rope, said the report by the Transportation Safety Board of Canada.

The helicopter was being flown at about 60 kt when the rope apparently slid up the external line and the bonnet opened. The report said that the bonnet then flew forward, into the helicopter's flight path, and the external line struck and disabled the tail rotor. The pilot was unable to deploy the emergency flotation system before the helicopter struck the water and sank.

The report noted that the pilot was wearing his lap belt but not the upper-body restraints; his helmet, which was fractured during the impact, protected his head from severe injury. "The pilot was able to exit the sunken helicopter but remained face down in the water," the report said. "He was wearing an uninflated lifejacket. The pilot was rescued within three minutes and revived, but remained in critical condition for several days."

### Unattended Helicopter Rolls Over

Bell 206B. Substantial damage. No injuries.

While preparing the helicopter to pick up passengers for a sightseeing flight in Boulder City, Nevada, U.S., the morning of Nov. 11, 2006, the pilot started the engine and completed the preflight checks. After checking generator load, he left the engine running at 100 percent rpm to charge the battery, the NTSB report said.

"The pilot exited the helicopter with the engine running and the rotors turning to disconnect the APU and to move it away from the helicopter," the report said. "While moving the APU, the pilot heard the engine sound change, turned around and saw the front skids lifting off the ground." The helicopter then moved backward and rolled down an embankment. ●



Preliminary Reports				
Date	Location	Aircraft Type	Aircraft Damage	Injuries
June 1, 2007	Zurich, Switzerland	Gulfstream G-V	minor	9 none
The nose landing gear did not extend on approach, and the flight crew conducted a go-around. Attempts to extend the nose gear were unsuccessful, and the crew landed the G-V with the nose gear retracted.				
June 3, 2007	Kashira, Russia	Robinson R44	substantial	1 fatal, 2 serious
The helicopter crashed under unknown circumstances during a local flight from Moscow. The pilot was killed.				
June 4, 2007	Milwaukee	Cessna Citation II	destroyed	6 fatal
Soon after departing on an air ambulance flight, the flight crew declared an emergency, reporting a runaway trim condition. The crew was attempting to return to Milwaukee when the airplane struck Lake Michigan.				
June 5, 2007	Simiti, Bolivar, Colombia	Bell 206L-3	substantial	2 fatal, 4 serious
Instrument meteorological conditions (IMC) prevailed when the helicopter struck mountainous terrain at 1,000 ft. The pilot and copilot were killed.				
June 10, 2007	Santa Barbara, California, U.S.	Dassault Falcon 900	substantial	15 none
The captain said that although he eventually pulled the control column back to his chest, the airplane did not rotate. The crew rejected the takeoff, but the Falcon overran the runway.				
June 13, 2007	Guipuzcoa, Spain	Bell 212	destroyed	2 fatal
IMC prevailed when the helicopter struck terrain during a positioning flight from Santander to Alicante.				
June 16, 2007	Chelinda, Malawi	Cessna U206F	destroyed	6 fatal
The airplane was on a sightseeing flight when it struck high terrain in visual meteorological conditions (VMC).				
June 26, 2007	Placitas, New Mexico, U.S.	Beech 58 Baron	destroyed	1 fatal
VMC prevailed when the Baron struck a mountain at about 10,000 ft during a business flight from Torrance, California, to Clinton, Oklahoma.				
June 18, 2007	Blenheim, New Zealand	Beech 1900D	substantial	17 none
The crew reported an unsafe landing gear indication on approach to Wellington. They diverted to Blenheim and conducted an intentional wheels-up landing.				
June 20, 2007	Boston	Embraer 135	minor	41 none
The crew observed a "landing gear lever disagree" warning during the flare and rejected the landing at Logan International Airport. The flaps were damaged when the airplane contacted the runway, gear-up, during the go-around. The crew manually extended the gear and landed at Logan without further incident.				
June 21, 2007	Kamina, Democratic Republic of Congo	LET 410	substantial	1 fatal, 24 NA
The airplane struck terrain on takeoff and came to a stop upside down in a swamp.				
June 23, 2007	Naryn, Kyrgyzstan	Yakovlev 40	destroyed	13 NA
Engine problems occurred after takeoff from Ysykkul Airport. The crew shut down two of the three engines and conducted an emergency landing in a field. There were no fatalities.				
June 25, 2007	Sihanoukville, Cambodia	Antonov An-24RV	destroyed	22 fatal
The airplane struck a mountain at 1,640 ft during approach.				
June 25, 2007	Treviso, Italy	Boeing 737-800	NA	181 none
The crew heard a loud bang during the landing. The nose landing gear axle had fractured, and the left nosewheel had separated.				
June 28, 2007	M'banza Congo, Angola	Boeing 737-200	destroyed	6 fatal, 73 NA
The 737 touched down about halfway down the 1,800-m (5,906-ft) runway, overran the runway and struck vehicles and buildings. The fatalities included one person on the ground.				
June 30, 2007	Saltillo, Mexico	North American Sabreliner 40	substantial	4 NA
The airplane landed long and overran the runway onto rocky soil. There were no fatalities.				
June 30, 2007	Conway, Arkansas, U.S.	Cessna Citation	destroyed	1 fatal, 1 NA
The Citation landed long on the 4,875-ft (1,486-m) runway, and the pilot attempted to go around. The airplane overran the runway and struck a building, killing the pilot.				
NA = not available				
This information, gathered from various government and media sources, is subject to change as the investigations of the accidents and incidents are completed.				