Out of the Loop

Controller was unable to communicate with pilots on a collision course.

BY MARK LACAGNINA

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

JETS

Faulty Frequency Changes

Airbus A319, Boeing 747. No damage. No injuries.

The flight crew of the A319, which was approaching Anchorage, Alaska, U.S., from the north, did not establish radio communication with the airport traffic (tower) controller when instructed to do so by the approach controller. The flight crew of the 747, taking off to the west, changed to the departure control radio frequency without having been instructed to do so by the tower controller. Thus, when the A319 initiated a go-around and turned into the path of the 747, the tower controller was unable to communicate with either crew.

Air traffic control radar data showed that the airplanes came within 100 ft vertically and one-third of a mile (a half kilometer) laterally, said the report by the U.S. National Transportation Safety Board (NTSB).

The near-midair collision occurred at Ted Stevens International Airport at 0010 local time on May 21, 2010. Visual meteorological conditions (VMC) prevailed, with surface winds from 290 degrees at 6 kt, 10 mi (16 km) visibility and a few clouds at 2,500 ft.

The airport has three runways. Runway 07R/25L was closed for construction, and Runway 25R and Runway 14 were in use. The runways intersect near the end of Runway 25R and at the extreme end of Runway 14 (which has since been redesignated as Runway 15).

The A319, with 133 passengers and five crewmembers aboard, was on a visual approach to Runway 14, and the 747, with two pilots aboard, was departing from Runway 25R for a cargo flight.

The A319 was about 5 nm (9 km) from the runway threshold when the tower controller cleared the 747 crew for takeoff. The tower controller then prompted the approach controller to instruct the A319 crew to change from the approach control radio frequency to the tower frequency. The Airbus was 2 nm (4 km) out when the approach controller issued that instruction. "The A319 acknowledged the instruction but did not contact the tower," the report said. "The tower controller made several attempts to establish communications with the A319 without success."

The Airbus was at 600 ft and about 1 nm (2 km) from the threshold of Runway 14 when the crew told the approach controller that they had encountered a tail wind and were conducting a missed approach. The approach controller told them to fly a heading of 190 degrees and to maintain 2,000 ft.

"Immediately after the A319 began the missed approach, the tower called approach control and asked if he was talking to the A319," the report said. "The approach controller advised the tower controller that the A319 reported a 'wind shear' and was going around. The

tower controller asked the approach controller to put the A319 on a heading of 160 [degrees] due to the 747 departing Runway 25R. The approach controller responded that he was going to turn the A319 'all the way to the right.'"

The approach controller had misunderstood the tower controller's request to issue a heading of 160 degrees to the A319 crew; he believed the tower controller was going to turn the 747 to that heading. As a result, the approach controller told the A319 crew to turn right to a heading of 300 degrees and advised them that a 747 was departing from Runway 25R and would be turning southbound. The crew acknowledged the heading assignment and said that they did not have the 747 in sight. The 747 crew actually was maintaining the runway heading, 250 degrees.

The approach controller also believed that the A319 would be able to complete the turn while remaining north of Runway 25R. However, the controller had "failed to account for the aircraft's groundspeed," which was 180 kt, the report said. "The above-average approach speed of the A319 resulted in the airplane overflying Runway 25R instead of turning inside the runway."

The airplanes flew parallel courses momentarily before their flight paths converged.

The airplanes flew parallel courses momentarily before their flight paths converged. The report noted that the A319 crew received a traffic-alert and collision avoidance system (TCAS) resolution advisory to descend but did not state how the crew responded to the advisory.

The tower controller had recognized the developing conflict and had radioed the 747 crew to turn left to a heading of 190 degrees. He repeated the instruction twice, but there was no response because the 747 crew was no longer on his radio frequency. "At the time of the event, the [tower] controller was not able to communicate with the A319 or the 747," the report said.

Pilot Exercises 'Wrong Motor Skill'

Airbus A300. No damage. No injuries.

Preparations for a flight from London Gatwick Airport to Crete with 335 passengers and 12 crewmembers on July 26, 2011, proceeded normally until the copilot moved the slats/flaps lever from the 0/0 position to 15/15 after the engines were started. The electronic centralized aircraft monitor generated a slat fault message, and the flight crew tried unsuccessfully to reset the system according to the quick reference handbook (QRH) procedure, said the report by the U.K. Air Accidents Investigation Branch (AAIB).

The crew then radioed company engineers, who advised that several reset attempts likely would be required to clear the slat fault. "This process involved tripping and resetting the relevant circuit breakers and then moving the slats/flaps lever to check if the slats operated," the report said. With the commander operating the circuit breakers and the copilot moving the slats/flaps lever, the fault eventually cleared.

The report said that the copilot had "developed and exercised a new motor skill" when he cycled the slats/flaps lever between 0/0 and 15/15, bypassing the 15/0 position, six times before the fault cleared. Normally during takeoff, the lever is moved from 15/15 to 15/0, then to 0/0 after airspeed increases.

Before departure, "the pilots discussed the possibility of the fault recurring on takeoff and reviewed the appropriate procedure, the first item of which was to cycle the slats/flaps lever," the report said.

Shortly after the A300 lifted off the runway, the copilot called, "Positive climb," and the commander, the pilot flying, replied, "Gear up." The copilot responded by moving the slats/flaps lever from 15/15 to 0/0.

"The distraction of the slat problem and the preoccupation with the possibility of a slat malfunction on departure had mentally predisposed him to exercise the wrong motor skill and to retract the slats and flaps despite his intention to operate the landing gear lever," the report said.

The commander did not immediately detect the copilot's mistake. He saw unexpected airspeed indications and confirmed that the appropriate pitch attitude and power settings for takeoff were being maintained. Then he noticed that the landing gear handle was still in the "DOWN" position and repeated the "gear up" call.

"The copilot informed the commander that he had inadvertently retracted the slats and then selected the landing gear lever up," the report said. "The stall warning system activated twice during the following 10 seconds [as the aircraft accelerated to the normal climb speed], and on both occasions the commander reduced the aircraft pitch attitude in response to the warning. The aircraft maintained a positive rate of climb throughout."

Angle-of-attack had increased from 5.6 degrees to about 8.0 degrees when the slats and flaps were inadvertently retracted, and airspeed had decreased from 176 kt to 166 kt before increasing again. "The aircraft accelerated to the normal climb speed, and the flight proceeded without further incident," the report said.

Heat Destroys Engine Nacelle

Boeing 777-200. Substantial damage. No injuries.

While departing from Singapore with 202 passengers and 12 crewmembers for a flight to London the afternoon of June 14, 2010, the flight crew received several engine indicating and crew alerting system (EICAS) messages about limited N_1 (fan speed) and the abnormal thrust being produced by the right engine.

"During the climb, the crew interrogated the system and established that the event had been transient," the AAIB report said. "The crew elected to continue en route while evaluating the situation. Possible causes [of the transient event] were considered to be a bird strike, fan damage, spurious indications or a failure within the EEC [electronic engine control] or associated systems."

Initially, the only unusual indications were that right-engine N_1 was 3.5 percent higher than left-engine N_1, while compressor speed, fuel flow and exhaust gas temperature were lower. Vibration levels were normal.

About four hours into the flight, the EICAS indicated that the right EEC had changed from the normal mode to the alternate mode. "This was not a cause for alarm for the crew, as they had suspected EEC issues," the report said. Per the QRH, the crew switched the left EEC to the alternate mode, also.

As the flight progressed, the crew determined that the thrust settings and fuel flows were higher than expected for cruise, and they planned diversions to alternate airports if the 777 could not be landed at Heathrow with the required reserves.

Nearly nine hours into the flight, "the relief crew heard a 'thud' and felt a slight movement of the aircraft," the report said. "They then noticed that the required thrust setting and fuel flow had reduced, and that the fuel state, although not showing insufficient for London, had stopped deteriorating."

An exterior panel had come loose, creating drag for several hours before detaching.

The noise also had awakened the commander from his rest. He initially believed the noise had been produced by a compressor stall, but the absence of further noises or abnormal engine indications and the reduction in the required thrust setting and fuel flow suggested that an exterior panel had come loose, creating drag for several hours before detaching.

The crew declared an urgency, diverted to Amsterdam, Netherlands, and landed the 777 without further incident. A visual inspection of the aircraft showed that "the right aft inner nacelle was severely damaged and largely missing, with further minor airframe damage," the report said, noting that some nacelle debris had been found on the runway at Singapore.

"Examination indicated that the nacelle damage was due to thermal disbond originating from the HP3 duct area," the report said. "There have been a number of separate but similar events in other airlines, and the airframe manufacturer has issued a series of service bulletins to reduce the rate of occurrence."

High Fuel Flow Traced to Spoilers

Airbus A380. No damage. No injuries.

The A380 was en route from Singapore to Melbourne, Australia, the morning of May 16, 2011, when the flight crew noticed that fuel consumption was about 600 kg (1,323 lb) per hour higher than planned. "The crew considered a possible fuel leak, but a high fuel flow

was deemed the most likely reason," said the report by the Australian Transport Safety Bureau.

The discrepancy built to approximately 3,800 kg (8,378 lb) over six hours, and the crew decided to divert to Adelaide because of possible delays at Melbourne, where the runways were undergoing maintenance. The A380 was landed without further incident, and "a subsequent inspection of the aircraft found no evidence of fuel system leaks or any engine anomalies that would account for excessive fuel use," the report said. "The aircraft was released back into service without any component replacement or system upgrades. None of the subsequent flights presented fuel discrepancies of note."

'All of the aircraft's flight spoilers were deflected slightly into the airstream.'

Further analysis of recorded data by Airbus and by the airline that operated the aircraft showed that the speed brake (spoiler) lever had been set to an angle of 3.6 degrees for more than four hours during the incident flight. "As a result, all of the aircraft's flight spoilers were deflected slightly into the airstream, creating additional drag and increasing the fuel burn during the flight," the report said.

A crew advisory normally is generated when the speed brake lever is set to an angle of 5.0 degrees. "To reduce the likelihood of a reoccurrence of the event, Airbus plans to reduce the alerting position of the speed brake lever angle from 5.0 degrees to 2.4 degrees," the report said.

Gear Handle Not Full Down

Gulfstream 200. Minor damage. No injuries.

The flight crew received indications that the landing gear was extended but not locked during a visual approach to Westchester County (New York, U.S.) Airport the morning of May 27, 2011. "Sounds associated with landing gear transit were heard; however, the landing gear cockpit indications displayed three red lights," the NTSB report said.

The crew conducted a go-around and entered a holding pattern to perform the appropriate checklist procedure. However, before they completed the procedure, which calls, in part, for the landing gear to be cycled, a right hydraulic system overheat warning was generated by the EICAS. The crew then completed the appropriate checklist procedure for the hydraulic system malfunction and returned to the landing gear malfunction checklist. They were unable to cycle the landing gear, however, because pressure in the right hydraulic system, which powers the gear, had fallen from the normal 3,000 psi to 1,500 psi.

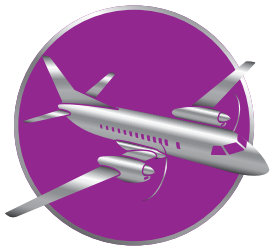
"The flight crew subsequently performed the emergency gear extension checklist items and utilized the emergency gear blow-down bottle," the report said. "The resultant cockpit indications were nose gear green, but the right and left main landing gear remained red." The airplane was flown past the airport traffic control tower, and controllers told the crew that all three landing gear appeared to be extended.

Nevertheless, the crew declared an emergency and diverted the flight to Stewart International Airport in Newburgh, New York, which has a longer runway. The right main landing gear collapsed shortly after touchdown, and "the airplane then settled on its right wing and slid to a stop on the runway," the report said. The pilots and their passenger were not hurt.

"During postaccident examination of the airplane, the landing gear selector handle was found 1/8 to 1/4 in [3 to 6 mm] from the full-down position," the report said. "Subsequent ground testing revealed that when the landing gear selector handle was positioned full-up, followed by full-down, the landing gear cycled successfully, indicating that if the flight crew had placed the handle in the full-down position, the landing gear would likely have operated normally."

With the landing gear extended but not locked, a hydraulic bypass had occurred, resulting in the increased hydraulic fluid temperature and decreased pressure. "The hydraulic bypass was most likely the reason that the landing gear did not lock when the emergency gear extension procedure (blow down) was followed," the report said, noting that the manufacturer subsequently modified the "Emergency Landing Gear Extension" checklist to include procedures

for a situation in which the gear does not extend and lock after a blow-down.



TURBOPROPS

Broken Bracket Jams Elevator

ATR 72. Minor damage. No injuries.

The airplane was en route to Dallas–Fort Worth (Texas, U.S.) International Airport with 41 passengers and four crewmembers the night of Dec. 25, 2009, when the flight crew received a pitch mistrim caution message. "In accordance with checklist procedures, they disconnected the autopilot and discovered that fore and aft movement of both control columns was stiff," said the NTSB report, issued in March 2012. "They could move the elevator controls a maximum of 1 in [3 cm] pitch-up and pitch-down."

The pilots completed the "Jammed Elevator" checklist twice, without success. "While coordinating with their company's maintenance operational control, they slowed the airplane to 180 kt and found that they had regained increased control of the elevator," the report said.

However, elevator control again felt stiff when the crew configured the ATR 72 for landing. They declared an emergency and conducted a go-around. "During the second landing attempt, the flight crew still had both control columns partially jammed," the report said. "They performed a shallow approach to a smooth landing."

Examination of the airplane revealed that the elevator had been partially jammed by down-limit-stop L-brackets that had fractured and separated from their hinge fittings. "The fractures were consistent with fatigue failure and were caused by a combination of improperly installed shim stacks, poor alignment of the L-brackets and cyclic stresses acting on the lower stop, which were generated by the repeated improper use of the gust lock system," the report said.

The gust lock must be engaged when the airplane is parked or is being taxied. However, recorded flight data showed numerous instances in which the gust lock had not been engaged after landing. "Therefore, the elevators were allowed to slam against the lower stops," the report said.

'Sleet Storm' Douses Engines

Britten-Norman Turbine Islander. No damage. No injuries.

The pilot was conducting his fifth "lift," with eight skydivers aboard, at Swansea (Wales, U.K.) Airport the morning of Aug. 27, 2011. "The weather conditions had been similar throughout the previous lifts, with about four oktas of cloud cover, the cloud being organized in lines, with clear air in between," the AAIB report said.

The climb was conducted in clear air to about 8,000 ft, and the pilot began a wide turn to position the Islander over the airport for the parachute drop. During the turn, the aircraft entered the side of a cloud, where outside air temperature was 0 degrees C. "The pilot reached down to select the engine anti-ice 'ON,'" the report said. "Before he could do so, the aircraft was enveloped in what the pilot described as a 'sleet storm.'"

Both engines ingested ice and flamed out. The pilot established the aircraft in a glide at 120 kt and completed the turn toward the airport. "The aircraft descended out of the cloud at about [7,000 ft], and the pilot selected the igniters 'ON' and the power levers to idle. Both engines relit immediately." The pilot landed the Islander without further incident.

"This incident illustrates the speed with which such a power loss can occur and that it can be total if power plant anti-icing is not selected 'ON' before such icing conditions are entered," the report said.

Frozen Flight Controls

Piaggio P180 Avanti. No damage. No injuries.

After about 1.5 hours in cruise at 26,000 ft the morning of Dec. 13, 2010, the flight crew began a descent to their destination, Port Columbus (Ohio, U.S.) International Airport, where the surface temperature was minus 9 degrees C (16 degrees F). At about 15,000 ft,

the yaw damper automatically disengaged, but the autopilot remained engaged.

"The captain instructed the first officer, who was the pilot flying, to check the freedom of the flight controls," the NTSB report said. "The first officer found the ailerons, elevator and rudder to be 'frozen' in place."

Both pilots exerted pressure on the controls until they "broke free with a 'snap,'" the report said. "The flight controls remained 'stiff and sticky' for the remainder of the flight. … On the ground, the flight controls and the nosewheel steering became inoperative. The flight crew used differential power and braking to taxi to the ramp."

Maintenance technicians found a buildup of ice in the belly of the fuselage and around the primary flight control cables and pulleys in that area.

The U.S. Federal Aviation Administration subsequently issued emergency airworthiness directive 2011-01-53, advising Avanti owners of three incidents of P180 flight control restrictions due to ice formation and requiring functional checks of fuselage drain holes.

PISTON AIRPLANES

CFIT in Deteriorating Weather

Piper Chieftain. Destroyed. Two fatalities.

The airplane departed from Goose Bay, Newfoundland and Labrador, Canada, the morning of May 26, 2010, to deliver a passenger and cargo to Cartwright. Rather than choosing an alternate route, the pilot flew a direct course to Cartwright, which took the Chieftain over mountainous terrain where marginal VMC prevailed, said the report by the Transportation Safety Board of Canada. The aircraft operator was certified to conduct charter flights only under day visual flight rules.

The last radio transmission from the pilot was a position report 60 nm (111 km) west of Cartwright at 0905 local time. A search was launched about an hour later, but it was hampered by adverse weather and the absence of an emergency locator transmitter signal, the report said.

The wreckage was found two days later about 100 ft below the crest of a 3,600-ft, snow-covered mountain. "The aircraft initially struck the ground … in a wings-level, horizontal attitude," the report said, noting that there was no sign of a pre-impact malfunction. The accident was classified as controlled flight into terrain (CFIT).

Control Lost During Autopilot Test

Cessna 310R. Destroyed. One fatality.

Following the installation of electronic flight instrument systems and a new autopilot in the airplane, functional check flights revealed a pitch divergence (porpoise) when the autopilot was engaged. After troubleshooting again was performed by avionics technicians the morning of March 11, 2011, the commercial pilot departed from Smyrna, Tennessee, U.S., for another check flight.

"Shortly after departure, the airplane entered a rapid, full-power, near-vertical descent from 2,700 ft above ground level to ground impact," the NTSB report said. The elevator trim actuator was found in the full-nose-down position.

The report said that a factor in the accident was "the pilot's decision to perform a test flight on a system for which he lacked a complete working knowledge."

A technician who had participated in a previous check flight said that the pilot had exerted back pressure on the control wheel with the autopilot engaged, inadvertently causing the autopilot to trim the elevator full-nose-down. The pilot responded by switching off the autopilot and trim master switches, "then attempting to trim the airplane with the electric trim that he had just disabled."

"According to the technician, the pilot yelled at him to turn the [autopilot] system off, and the technician responded that it was off," the report said. The pilot then used the manual trim system to alleviate the control forces.

"After the flight, I told [the pilot] he needed to go back and get in the books and learn to operate the system," the technician said. "He seemed very disoriented with the new technology."

The pilot conducted the subsequent check flight alone. "Based on the available evidence, it is likely that after autopilot engagement, the airplane pitched down [and] the pilot pulled back on the yoke in an effort to arrest the airplane's descent," the report said. "As a result, the autopilot would have commanded the trim further toward the nose-down position. Such a scenario would require a greater and ever-increasing physical effort by the pilot to overcome the growing aerodynamic force that would result from the nose-down pitch and increasing speed of the airplane.

"The pilot may have removed one hand from the yoke to again reach for the panel-mounted trim and/or autopilot master switches. … He may have lost his single-handed grip on the control yoke, and the airplane descended in an unrecoverable nose-down attitude."

Hydraulic Leak Disables Gear

Piper Chieftain. Substantial damage. No injuries.

During final approach to Providenciales Airport in the Turks and Caicos Islands the night of April 2, 2011, the pilot received an indication that the landing gear was not extended and locked. He flew by the airport traffic control tower, and a controller reported that the gear appeared to be only partially extended, the AAIB report said.

The pilot entered a holding pattern and attempted unsuccessfully to manually extend the landing gear. He then was instructed by the controller to divert to JAGS McCartney Airport on Grand Turk, "to avoid blocking the [Providenciales] airport's single runway and causing delays to scheduled airline flights," the report said.

A controller at the Grand Turk airport also told the pilot that the landing gear was only partially extended. The pilot prepared his five passengers for a gear-up landing and closed the fuel selector valves just before touchdown. The Chieftain came to a stop near the right edge of the runway. There was no fire, and the occupants exited through the main cabin door.

Examination of the aircraft revealed that a hydraulic line leading to the right main landing gear door actuator had failed. The resulting loss of hydraulic fluid had prevented the normal and emergency gear-extension systems from functioning properly.

HELICOPTERS

Fuel Exhausted on Pleasure Flight

Fairchild Hiller 1100. Destroyed. Four fatalities.

The private pilot was conducting his first flights with passengers on May 23, 2010, after completing training in the helicopter. He had 100 flight hours, including 12 hours in type. The passengers had won raffle tickets for local pleasure flights from the pilot's private helisite in Morbach, Germany.

Witnesses who saw the helicopter returning to the helisite on its third flight heard a sound, identified by investigators as an engine flameout, before it descended rapidly to the ground.

"The accident occurred following a failed autorotation, or the failure to initiate an autorotation, after the engine stopped due to fuel exhaustion," said the report by the German Federal Bureau of Aircraft Accident Investigation.

Drooping Conduit Snags Vertical Fin

Bell OH-58C. Substantial damage. Two minor injuries.

The pilot had hover-taxied the police helicopter from its hangar at an airport in Panama City, Florida, U.S., numerous times without event. However, while doing so the afternoon of May 27, 2011, the pilot heard a loud bang when the helicopter was almost out of the hangar.

"He started to lower the collective but could not control the helicopter," the NTSB report said. The main rotor blades and tail rotor drive shaft separated, and the tail boom was twisted about 120 degrees when the helicopter struck the ground and came to rest on its left side. The pilot and observer sustained minor injuries.

Investigators determined that a coiled electrical conduit secured above the hangar door frame likely had become loose after the helicopter's main rotor passed below and then had detached, uncoiled and drooped below the door frame, snagging the helicopter's vertical tail fin.

Preliminary Reports, March 2012

Date	Location	Aircraft Type	Aircraft Damage	Injuries
March 1	Isla Grande de Chiloé, Chile	Piper Navajo	destroyed	8 fatal
The Navajo struck a mountain shortly after departing from Melinka in rain, fog and strong winds for a flight to Quellón.				
March 1	Egelsbach, Germany	Cessna Citation X	destroyed	5 fatal
Night instrument meteorological conditions (IMC) prevailed when the Citation crashed in a wooded area on final approach.				
March 3	Detroit, Michigan, U.S.	McDonnell Douglas MD-88	substantial	144 none
The MD-88 was being taxied to a gate when its left wing tip struck and overturned an unoccupied shuttle bus.				
March 5	Yellowknife, Northern Territories, Canada	Lockheed L-188A Electra	minor	5 none
The Electra veered off the runway on landing after the flight crew was unable to extend the right main landing gear.				
March 5	Terceira, Azores, Portugal	Airbus A340-313X	none	288 none
The A340 was en route from France to Colombia when a burning odor from a short circuit in a crew rest area permeated the cabin. The flight crew conducted an emergency descent to 2,000 ft and diverted to Terceira.				
March 5	Anchorage, Alaska, U.S.	Learjet 35A	substantial	6 none
The flight crew's forward visibility was impaired when the windshield iced over just before touchdown. The air ambulance then veered off the runway and struck a snow bank.				
March 8	Comayagua, Honduras	Rockwell Commander 500S	destroyed	2 fatal
Witnesses saw the airplane flying low before it struck trees during a cargo flight from San Pedro Sula to Tegucigalpa.				
March 8	Ronaldsway Airport, Isle of Man	BAE Systems Jetstream 31	substantial	14 none
Investigators found that stress corrosion cracking caused the right main landing gear to fail and the airplane to veer off the runway on landing.				
March 12	Gulf of Mexico	Bell 206L-3 LongRanger	substantial	1 none
The helicopter had been tied down overnight on an offshore oil platform. The pilot neglected to disconnect one of the four tie-downs, and the LongRanger rolled onto its right side during the subsequent takeoff attempt.				
March 13	Ketchikan, Alaska, U.S.	de Havilland Beaver	substantial	1 serious, 1 minor
The floatplane crashed in IMC about 23 mi (37 km) from Ketchikan while returning from a mining site.				
March 13	Atlanta, Georgia, U.S.	Boeing 737-700	substantial	2 none
Maintenance technicians had problems with the braking system while testing the 737's engines. The airplane overran the taxiway and traveled down an embankment.				
March 14	Jos, Nigeria	Bell 427	destroyed	12 fatal
Seven people in the police helicopter and five on the ground were killed when the aircraft crashed into a house during a surveillance flight.				
March 15	San Juan, Puerto Rico	Convair 340	destroyed	2 fatal
The cargo airplane crashed in a lagoon shortly after the flight crew declared an emergency on takeoff because smoke was coming from an engine.				
March 15	Franklin, North Carolina, U.S.	Cessna Citation 501	destroyed	5 fatal
Witnesses heard engine noise increase after the Citation touched down about halfway down the 5,000-ft (1,524-m) runway and bounced. The airplane then banked right and crashed off the side of the runway.				
March 22	Puerto Aguirre, Chile	Beech King Air 350	destroyed	8 fatal
The King Air struck a mountain during a night air ambulance flight from Punta Arenas to Santiago de Chile.				
March 28	Broken Bow, Nebraska, U.S.	Beech E55 Baron	destroyed	1 fatal, 2 serious
The Baron crashed in a cornfield during an attempted emergency landing at the airport.				
March 29	Wau, South Sudan	Fokker 50	substantial	5 minor, 50 none
The landing gear collapsed after the Fokker touched down on a runway that was being repaved.				
March 31	Tokyo, Japan	Boeing 777-200	substantial	308 none
The tail struck the runway when the flight crew initiated a go-around because of strong gusts. The 777 subsequently was landed without further incident.				

This information, gathered from various government and media sources, is subject to change as the investigations of the accidents and incidents are completed.