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**

**Fuselage Skin Torn Near Cargo Door**


After departing from Syracuse, New York, U.S., for a scheduled flight to Detroit on May 18, 2007, the DC-9 was climbing through 20,000 ft when the flight crew heard a loud pop and the cabin depressurized. "The flight crew donned their oxygen masks and initiated an emergency descent to 10,000 ft," said the report by the U.S. National Transportation Safety Board (NTSB).

After reaching 10,000 ft, the crew diverted to the closest suitable airport, Buffalo Niagara (New York) International, where the airplane was landed without further incident. None of the 95 passengers and four crewmembers was injured. "After landing, the airplane was inspected by airport emergency personnel and taxied to the gate," the report said.

A postflight examination by a U.S. Federal Aviation Administration (FAA) inspector revealed a 12-in by 5-in (30-cm by 13-cm) tear in the fuselage skin about 6 ft (2 m) forward of the forward cargo door on the right side of the airplane. "Further inspection revealed that a crease in the skin of the fuselage existed forward of the tear, consistent with the skin being damaged by a foreign object," the report said.

Airline personnel and FAA inspectors found metal shavings on the ramp where the DC-9 had been parked at Syracuse Hancock International Airport. "Examination of the belt loader used during the loading process revealed that [it] had red paint flakes adhering to the front right-hand corner, which matched the height of red paint scrape marks on the front left bumper of a luggage tug. The top right-hand forward corner of the luggage tug exhibited scrape marks, missing paint and exposed metal."

The airline’s station manager and ground agents for the contracted ramp-service company told investigators that the belt loader’s engine had failed either while luggage was being off-loaded or loaded before the accident flight. "Three of the contractor’s ground agents attempted to manually push the belt loader away from the airplane but were unable to do so," the report said. "The senior of the three decided to use the luggage tug to push the belt loader away from the airplane."

The senior ground agent positioned the luggage tug parallel to the airplane’s fuselage and within the designated safety zone in which
luggage-tug operations are prohibited. "At some point during or immediately after pushing the belt loader away from the airplane, the upper right-hand side of the tug’s cab contacted the fuselage," the report said. "The senior ground agent then advised ‘don’t say anything’ to one of the other ground agents who was working the flight with him.”

NTSB determined that the probable cause of the accident was “the senior ground agent’s failure to follow written procedures and directives.” The report said that among actions taken by the contractor after the accident was publication of a memo to station personnel that stated: “It is imperative that when a piece of equipment comes in contact with an aircraft, leaving a scratch, dent, hole, etc., the incident must be reported immediately. … It is beyond a concern of potential discipline; it is the ultimate significance of ensuring there is no risk to the safety of flight.”

**Low Energy, Wind Shear Lead to Tail Strike**

Avro RJ100. Substantial damage. No injuries.

Inbound from Zurich, Switzerland, the flight crew was conducting an instrument landing system (ILS) approach to Runway 28 at London City Airport the morning of Aug. 18, 2007. Visual meteorological conditions (VMC) prevailed, and surface winds were from 190 degrees at 10 kt.

“At between 50 and 30 ft above the runway, the pilots felt the aircraft ‘dropping,’ and the commander … pulled back on the control column to prevent a hard landing,” said the report by the U.K. Air Accidents Investigation Branch (AAIB). The Avro’s pitch attitude increased to 9.3 degrees, and the lower aft fuselage struck the runway before the aircraft touched down on the main landing gear.

There were no injuries among the 88 passengers and five crewmembers. "Neither the pilots nor the cabin crew were aware that there had been a tail strike, although the rear cabin crewmember reported that there had been a loud noise on touchdown,” the report said.

An analysis of RJ100 and BAE 146 tail-strike events by British Aerospace showed that key causal factors are: airspeeds below the target landing reference speed (Vref); high rates of descent leading to higher pitch attitudes in the flare; and excess speed causing the aircraft to float and touch down with a high pitch attitude.

London City’s Runway 28 has an available landing distance of 1,508 m (4,948 ft), and the ILS glideslope angle is 5.5 degrees. "For a successful steep approach onto the relatively short runway, a high degree of accuracy needs to be achieved,” the report said, noting that thrust settings typically are lower than normal during such an approach.

The Avro had encountered turbulence during the approach, and recorded flight data showed that airspeed was 4 kt below Vref when the slight, variable headwind sheared to a slight tailwind about 50 ft above ground level (AGL) at the same time the commander moved the thrust levers to flight idle.

"The aircraft was already in a low energy state; then thrust was reduced,” the report said. “A combination of these factors reduced the energy of the aircraft, which was felt as a ‘sink’ by the pilots.” The commander’s instinctive movement of the control column caused pitch attitude to increase above the tail-strike attitude of 7 degrees. Vertical acceleration was 2.3 g when the tail struck the runway.

**Incorrect Stabilizer Trim Cited in Overrun**

Dassault Falcon 900. Substantial damage. No injuries.

While preparing for a flight from Santa Barbara, California, U.S., to Tampa, Florida, the afternoon of June 10, 2007, the first officer calculated a gross takeoff weight of 45,400 lb (20,593 kg) and entered a rotation speed of 129 kt on the takeoff and landing distance (TOLD) card. He did not calculate the center of gravity (CG) location.

Before takeoff, the flight crew set the stabilizer trim at minus 5.5 degrees, which corresponds with an aft CG. The takeoff range for stabilizer trim is minus 4.5 degrees to minus 7.5 degrees, according to the NTSB report.

The captain, the pilot flying, told investigators that the takeoff roll was normal until the
first officer called “rotate.” The captain pulled back on the control column (yoke), but the Falcon did not respond. “When the speed was well into the upper 130-kt range, he relaxed the yoke, then pulled aft again; and, again, there was no response from the airplane,” the report said.

The captain said that the airplane “did not even try to lift off” and, with the runway end approaching rapidly, he decided to reject the takeoff because “the odds of a possible airborne crash were greater than a runway/clearway type of incursion.”

He pulled the thrust levers back to the stops and applied maximum brake pressure and full forward pressure on the control column. He also told the first officer and passengers to brace themselves. The airplane overran the 6,055-ft (1,846-m) runway, struck a berm and came to a stop 580 ft (177 m) beyond the threshold.

The nosegear separated during the overrun, and the forward section of the Falcon’s pressure vessel was damaged substantially. There were no injuries among the 15 people aboard the airplane.

Investigators determined that the Falcon’s takeoff weight was 1,081 lb (490 kg) heavier than the first officer had calculated, the correct rotation speed was 131 kt and the CG was at minus 15.73 percent mean aerodynamic chord. “The right setting for the stabilizer trim should have been between minus 7.0 and minus 7.5 degrees,” the report said.

Tests in a Falcon 900 flight simulator showed that at the accident airplane’s gross weight, stabilizer setting and calculated rotation speed, there is a delay of 2 to 4 seconds between up-elevator input and the airplane’s reaction to the control input. “When the simulator was configured with the stabilizer trim set to minus 7.0 degrees and the V-speeds set for 46,480 lb [21,083 kg], there was no delay in airplane response to elevator input,” the report said.

**Towing Error Damages Two Aircraft**

**Bombardier Global Express. Substantial damage. No injuries.**

The aircraft was being towed to a parking area on a closed runway at Dublin (Ireland) Airport the afternoon of July 4, 2007, when its right wing tip struck the nose of another Global Express that was parked on the runway. The towed aircraft’s right wing pushed the parked aircraft’s nose sideways and onto the roof of a crew van. Both aircraft and the van were substantially damaged, but no one was injured, said the report by the Irish Air Accident Investigation Unit.

The tug driver told investigators that before he had attached the towbar to the aircraft, the tug’s windshield had cracked and fallen into the cab. “He secured the windscreen alongside himself in the cab and decided to undertake the tow,” the report said. “There was no radio on the tug, so ATC [air traffic control] clearance was coordinated by a marshaller who was driving the crew van.”

The parked aircraft had been correctly positioned behind a red line on the runway that designated the parking-area boundary. The report noted, however, that there were “a significant number of lines or markings on the disused runway, [including] old runway markings, roadway markings …, old taxiway lines and new taxi lines.”

The tug driver told investigators that he was confused by two taxi lines on the runway. “The driver did not follow either but went to some extent between them,” the report said. “He kept to the right of the new … taxi line and to the left of the old taxi line, which led directly up the white centerline of the runway.”

The marshaller drove the crew van ahead of the tug. After passing the parked Global Express, she stopped the van beside it, got out and removed chocks that were in the intended parking space for the towed aircraft. The tug driver said that he “knew she wanted him to go past the [parked] aircraft and reverse in,” the report said. “He slowed down [and] saw the marshaller standing on the red line, but she did not signal any warning. He then felt a bump.”

The marshaller said that after removing the chocks, she “moved back to wing-mark [the towed aircraft] into place [but] had not reached the van when the impact occurred.”

**The tug driver told investigators that he was confused by two taxi lines on the runway.**
“Though there was no disagreement between the statements of the tug driver and the marshaller regarding the position of the marshaller at the time of the incident; both stated that no wing-marker [wing-walker] was in position,” the report said. “However, the driver should have stopped and either waited until the marshaller was in a position to act as wing-marker or otherwise communicated to the marshaller that one was required in position in accordance with the aerodrome procedures in force at the time.”

**Delaminated Tire Bursts on Takeoff**
Boeing 737-800. Minor damage. No injuries.

The 737 was accelerating though 100 kt on takeoff from Phoenix Sky Harbor International Airport the night of Nov. 25, 2007, when the “ANTISKID INOP” warning light illuminated. “The takeoff was continued, and no other anomalies were noted,” the NTSB report said. “Soon after leveling at [Flight Level] 330, the crew was advised by ATC that tire fragments had been found on the runway and that they had possibly had a tire failure on takeoff.”

The flight crew then noticed that hydraulic system A was losing fluid and decided to land at the nearest suitable airport, Denver International. “After declaring an emergency, the crew made an overweight landing using 40 degrees of flap,” the report said. “The crew allowed the airplane to roll almost the full length of the runway and stopped on a taxiway. The airplane was then towed to the gate.” None of the 160 passengers and six crewmembers was injured.

“Postaccident inspection revealed the tread on the right outboard tire had come off and had struck the inboard and mid-span flaps, necessitating their replacement,” the report said. “In addition, the leading edge of the right horizontal stabilizer had been struck and required replacement.”

NTSB determined that the probable cause of the incident was “delamination of the right outboard tire during the takeoff roll due to underinflation and/or overloading during use in service.”

**Dual Flameout Remains a Mystery**
Gates Learjet 25B. Substantial damage. No injuries.

The flight crew was conducting a positioning flight to St. Augustine (Florida, U.S.) Airport in VMC the afternoon of July 21, 2007. The Learjet was at 5,000 ft, about 5 nm (9 km) from the destination, when both engines flamed out after the first officer, the pilot flying, moved the power levers back to begin the descent, the NTSB report said.

The captain attempted unsuccessfully to restart the engines. He then took control and landed the airplane on St. Augustine’s Runway 13. After touching down hard just past the threshold of the 7,996-ft (2,437-m) runway, both main landing gear tires burst. “A postaccident inspection by an FAA inspector revealed that the airplane had incurred substantial damage to the wings and fuselage during the landing,” the report said.

The investigation failed to determine conclusively why the engines had flamed out. “Both engines were test-run following the accident at full and idle power with no anomalies noted,” the report said.

However, the report noted some “issues” found in the Learjet’s aftermarket throttle quadrant: “The power lever locking mechanism pins, as well as the throttle quadrant idle stops for both engines, were worn. The power lever locking mechanism internal springs for both the left and right power levers were worn and broken. Additionally, it was possible to repeatedly move the left engine’s power lever directly into cutoff without first releasing its power lever locking mechanism; however, the right engine’s power lever could not be moved to the cutoff position without first releasing its associated locking mechanism.

“Other than the throttle quadrant issues, no other issues were identified with either the engines or airframe that could be [attributed] to both engines losing power simultaneously.”
TURBOPROPS

Close Call in Blowing Snow
Swearingen Metroliner. No damage. No injuries.

Weather conditions at Denver International Airport the morning of Jan. 5, 2007, included 1/2-mi (800-m) visibility in light snow and mist, a 600-ft overcast and surface winds from 030 degrees at 12 kt. The Metroliner pilot received instructions from the airport ground traffic controller to taxi from the cargo area, which is on the south side of the airport, to Runway 34R for takeoff.

The instructions called for the pilot to taxi north on a taxiway that parallels Runway 35L, which is on the east side of the airport, and then turn left on a taxiway leading to Runway 34R, which is on the west side of the airport.

The pilot told investigators that the blowing snow reduced his visibility and that snow covering the taxiway leading from the cargo area prevented him from seeing the taxiway-centerline lighting. “As he attempted to find the centerline lighting, he saw blue taxi lights, followed them and turned onto Runway 35L,” said the NTSB report. The Metroliner entered Runway 35L near the approach threshold, and the pilot began to taxi north on the runway.

About one minute later, the ground controller asked the pilot for the airplane’s position. The pilot replied that he was abeam the general aviation fixed-base operator. “According to the pilot, once the controller asked for his location, he noticed that he was on a runway,” the report said.

Meanwhile, the flight crew of an Airbus A319, inbound from St. Louis with 50 people aboard, was conducting an ILS approach to Runway 35L and had been cleared to land by the local traffic controller.

The A319 first officer, the pilot flying, told investigators that the airplane broke out of the clouds at about 600 ft AGL. “[The captain and I] looked down the runway and confirmed verbally to each other that the runway was clear,” he said. “We didn’t see the [Metroliner] until we were about 100 to 50 ft or so above the deck. When it did come into sight, it was at least 2,000 ft [610 m] down the runway. The winds, combined with the prop wash from the aircraft [and] the blowing snow, had caused it to be obscured and out of sight. I immediately commenced a go-around.”

The A319 crew already had initiated the go-around when the airport movement area safety system (AMASS) generated an aural and visual alert in the control tower. “Four seconds later, the [local] controller instructed [the A319 crew] to go around,” the report said. “The aircraft missed colliding by approximately 50 ft.”

NTSB concluded that the probable cause of the incident was the Metroliner pilot’s inadvertent entry onto the active runway. “A contributing factor to the incident was the failure of the Denver tower ground and local controllers to detect the aircraft on the [AMASS] display and issue a go-around instruction to the arrival flight crew.”

Flight Continued With Open Door
Let L410. Minor damage. No injuries.

The unpressurized twin-turboprop aircraft was departing with 16 passengers from Belfast City (Northern Ireland) Airport the morning of April 28, 2008, when the right nose baggage door opened. “The crew reduced speed to 120 kt and, as there was no vibration and the door appeared to be stabilized in the open position, decided to continue to their destination [Ronaldsway, Isle of Man],” said the AAIB report.

The commander, who was a company line training captain, told ATC that the baggage door had opened, but he did not declare an emergency. “On the approach to Ronaldsway, the crew requested, and were given, wide vectoring for a long final,” the report said. The L410 was landed without further incident. The baggage door had buckled and was torn near the latching mechanism, and one piece of baggage was missing.

“The incident occurred because the right nose baggage door had probably been incorrectly closed prior to departure,” the AAIB said. The report noted that the latch can be placed flush with the door, giving the appearance that the door is locked, even though the inner hook has not engaged the catch. “A modification is available to fit a physical indicator to the front door locking
A review of ATC radar data indicated that the Caravan was in a steep climbing turn when it apparently stalled at about 8,800 ft, descended rapidly and struck terrain at 6,073 ft near Oak Glen, California. Witnesses said that they had seen the airplane emerge from the clouds “almost straight nose-down.” Examination of the wreckage revealed no sign of mechanical malfunction or failure, the report said.

**PISTON AIRPLANES**

**Valley Airport Blanketed by Fog**


Most of the area near the business flight’s destination had VMC, with clear skies and almost unlimited visibility, the morning of Nov. 6, 2007. However, the destination, Garberville (California, U.S.) Airport is located in a narrow river valley and was covered with a layer of fog about 250 ft thick, the NTSB report said. The uncontrolled airport had no instrument approaches.

“Witnesses reported that the pilot flew at low level up the valley and eventually entered the fog,” the report said. “About one mile prior to reaching the airport, the pilot attempted to climb out of the valley, but the airplane began impacting trees on the rising terrain [about 0.25 mi (0.40 km) from the airport]. All of the witnesses stated that the engines ran strong and smooth until the final impact.”

**Engine Failure Leads to Ditching**

*Piper Cherokee Six. Destroyed. Four minor injuries.*

The pilot of the single-engine aircraft was conducting a VFR charter flight from Horn Island to Warraber Island, both in Queensland, Australia, the morning of May 23, 2007. Before boarding the three passengers, he briefed them on the Cherokee’s emergency equipment, including the life jackets, said the report by the Australian Transport Safety Bureau.

The islands are about 75 nm (139 km) apart in Torres Strait. “The planned cruise altitude was 1,500 ft, but, due to some cloud and turbulence at that altitude, the pilot revised the cruise altitude to 3,500 ft,” the report said.

The Cherokee was about 25 nm (46 km) from the destination when the pilot attempted to reduce power to begin the descent. However, propeller speed momentarily increased to 3,000 rpm before a total power loss occurred and the constant-speed propeller “began slowly windmilling in a shuddering manner,” the report said.

The pilot attempted unsuccessfully to restart the engine. He radioed the company that the flight was “going down,” then told the passengers to don their life jackets but not to inflate them. “He then donned his own life jacket and prepared the aircraft for ditching,” the report said. “When the aircraft impacted the water, it pitched steeply nose-down, then settled back into a near-level attitude.” All the occupants sustained minor injuries but were able to exit the Cherokee before it sank.

A search-and-rescue helicopter crew dropped two life rafts, but the survivors did
not know how to inflate them. After spending nearly an hour in the water, the survivors were winched aboard a rescue helicopter.

The Cherokee was not recovered, and investigators could not determine conclusively what caused the engine failure. However, the report said that it likely was caused by a problem with the forward crankshaft bearing.

**Corrosion Cited in Wing Separation**
Hello Super Courier. Substantial damage. Four fatalities.

The float-equipped airplane was being used to transport sport fishermen from a remote lake to a lodge near King Salmon, Alaska, U.S., on Sept. 30, 2007. “The pilot contacted lodge personnel while en route and estimated his arrival time in about three minutes,” the NTSB report said. “When the airplane failed to arrive, an aerial search discovered the wreckage about 10 miles [16 km] from the lodge.”

Examination of the wreckage showed that a corrosion-induced fatigue fracture had caused an attachment fitting in the left wing to fail. The report said that this resulted in an uncontrolled descent when the left wing partially separated from the fuselage.

The Courier had accumulated about 8,700 flight hours, including about 1,800 hours since the wings were replaced following an accident in October 2000. The new wings had been acquired from a salvage dealer that closed in 2006 and retained no records of the transaction.

**HELICOPTERS**

**Test Flight Ends With Fuel Exhaustion**

On March 22, 2007 — the day before the helicopter was to be delivered to its new owner, a company based in Italy — two ferry pilots arrived in Broby, Sweden, to conduct a brief test flight. “One of the pilots was trained on the type and was to be the commander, while the other, without training on the type, was to be a passenger,” said the report by the Swedish Accident Investigation Board.

The previous owner told investigators that the preflight preparations were rushed, “as if the pilot was in a hurry.” The report said that the helicopter had less than 50 L (13 gal) of fuel and that the low-fuel warning lights likely illuminated before takeoff from a farm field.

The previous owner and another witness saw the Gazelle hover over the field for several minutes before flying a circuit around the field, landing, lifting off and beginning another circuit of the field. They said that the Gazelle was at about 500 ft AGL when the engine failed. “This caused no immediate alarm, as extensive open fields were available to the pilot to make a controlled landing,” the report said.

As the witnesses drove toward the assumed landing site, however, they saw the pilots walking toward them and the helicopter on its side, badly damaged. “The fact that the helicopter was equipped with safety [harnesses] of four-point type may explain why those on board were not seriously injured,” the report said.

Estimating that the helicopter had used 43 L (11 gal) of fuel during the 11-minute flight, the report said that the cause of the accident was “engine failure because of a lack of fuel due to inadequate preflight preparations.”

**Pilot Struck by Turning Rotor Blades**
Bell 407. No damage. One fatality.

The pilot shut down the engine after landing at Morristown, Tennessee, U.S., on Nov. 9, 2007, but did not tighten the cyclic friction lock. After escorting the passengers to the fixed-base operator, the pilot was walking back toward the helicopter when he was struck by the still-moving main rotor.

A witness said that the rotor blades were tilted forward and that the blade tip path was about 5 1/2 ft (2 m) off the ground.

“The flight manual did not describe a procedure for the pilot to exit the helicopter while the engine and rotor continued to operate but did state that during shutdown, the pilot should ‘remain on the flight controls until the rotor has come to a complete stop,’” the NTSB report said.
## Preliminary Reports

<table>
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<tr>
<th>Date</th>
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<th>Aircraft Type</th>
<th>Aircraft Damage</th>
<th>Injuries</th>
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</thead>
<tbody>
<tr>
<td>Nov. 1, 2008</td>
<td>Western Guyana</td>
<td>Beech King Air A90</td>
<td>NA</td>
<td>3 NA</td>
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<tr>
<td>Nov. 1, 2008</td>
<td>Near Vaalwater, South Africa</td>
<td>Cessna 208B</td>
<td>destroyed</td>
<td>1 serious, 5 none</td>
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<tr>
<td>Nov. 1, 2008</td>
<td>Toksook Bay, Alaska, U.S.</td>
<td>CASA 212-200</td>
<td>substantial</td>
<td>2 minor</td>
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<tr>
<td>Nov. 2, 2008</td>
<td>Graz-Thalerhof, Austria</td>
<td>Piper Seneca III</td>
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<tr>
<td>Nov. 3, 2008</td>
<td>Punta Chivato, Mexico</td>
<td>Beech Super King Air 200</td>
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<tr>
<td>Nov. 4, 2008</td>
<td>Mexico City, Mexico</td>
<td>Learjet 45</td>
<td>destroyed</td>
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<tr>
<td>Nov. 6, 2008</td>
<td>Fakfak, Indonesia</td>
<td>Dornier 328</td>
<td>substantial</td>
<td>36 none</td>
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<td>Nov. 7, 2008</td>
<td>Bathurst, Australia</td>
<td>Piper Chieftain</td>
<td>destroyed</td>
<td>4 fatal</td>
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<tr>
<td>Nov. 8, 2008</td>
<td>Mount Kilimanjaro, Tanzania</td>
<td>Cessna U206F</td>
<td>destroyed</td>
<td>4 fatal, 1 serious</td>
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<td>Nov. 10, 2008</td>
<td>Rome</td>
<td>Boeing 737-800</td>
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<tr>
<td>Nov. 13, 2008</td>
<td>Detroit</td>
<td>Bombardier CRJ200</td>
<td>substantial</td>
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<tr>
<td>Nov. 13, 2008</td>
<td>Al Asad, Iraq</td>
<td>Antonov An-12B</td>
<td>destroyed</td>
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<td>Nov. 16, 2008</td>
<td>Thormanby Island, Canada</td>
<td>Grumman G-21A Goose</td>
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<td>7 fatal, 1 serious</td>
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<tr>
<td>Nov. 18, 2008</td>
<td>Göteborg, Sweden</td>
<td>British Aerospace Avro RJ100</td>
<td>minor</td>
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<td>Nov. 22, 2008</td>
<td>God's Lake Narrows, Canada</td>
<td>Beech King Air A100</td>
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<tr>
<td>Nov. 23, 2008</td>
<td>Recife, Brazil</td>
<td>Beech Super King Air 200</td>
<td>destroyed</td>
<td>2 fatal, 8 NA</td>
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<td>Nov. 27, 2008</td>
<td>Perpignan, France</td>
<td>Airbus A320-200</td>
<td>destroyed</td>
<td>7 fatal</td>
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</table>

The A320 was on a postmaintenance test flight when it struck the Mediterranean Sea on approach to Perpignan Airport.

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.