

Nose Gear Jammed

Landing conducted on mains.

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

Problem Traced to Broken Spray Deflector

McDonnell Douglas MD-90-30. Substantial damage. No injuries.

The airplane was on final approach in visual meteorological conditions (VMC) to Denver International Airport the evening of Oct. 11, 2006, when the flight crew observed a nose landing gear “UNSAFE” warning light while trying to extend the gear.

The crew flew the airplane near the airport traffic control tower, and tower personnel told the crew that the nose gear did not appear to be extended, said the U.S. National Transportation Safety Board (NTSB) report.

After consulting with airline maintenance personnel, the crew attempted unsuccessfully to lower the nose gear once more. They decided to land the airplane on Runway 16R, which is 16,000 ft (4,877 m) long and 200 ft (61 m) wide. The flight attendants briefed the passengers for the landing.

The airplane touched down on the main landing gear about 1,000 ft (305 m) beyond the runway threshold. The nose section contacted the runway 5,200 ft (1,585 m) beyond the threshold.

“As the nose section skidded on the runway, a small fire erupted in the nosewheel well area and self-extinguished,” the report said. “The nose gear doors were scraped, and the aluminum skin just aft of the nosewheel well was scraped through, exposing five longerons and six stringers [and] compromising the pressure vessel. Two antennas and one drain mast were also broken off.”

The crew stopped the airplane with 8,800 ft (2,682 m) of runway remaining and decided not to order an emergency evacuation. None of the 155 occupants of the airplane was injured. The passengers exited through the cabin door and were transported by bus to the terminal. The airplane was towed off the runway to a secure area.

“Postaccident examination [by airline maintenance personnel] revealed that the nose landing gear center spray deflector had fractured and rotated, preventing gear extension,” the report said. “The spray deflector is designed to deflect water and other runway material kicked up by the nosewheel away from the rear-mounted engines. [Otherwise, ingestion of debris] could cause flameouts and engine damage.”

The spray deflector assembly on the MD-90 is attached to the nose gear and consists of seven main components: the center deflector, two rear deflectors, two side deflectors and two supports.

Examination of the failed assembly at the NTSB Materials Laboratory revealed that the

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center deflector had fractured around the two bolts that attach it to the left side deflector. The laboratory report said, “Magnified optical examinations of both fractures uncovered uniformly rough, gray fracture features typical of overstress separations in aluminum castings. Fracture features and fracture orientations were consistent with downward bending loads on the left deflector.”

The accident airplane was built in 1995 and had accumulated 31,747 hours and 16,739 cycles. The airline inspected other MD-90s and MD-88s in its fleet, and found a cracked spray deflector assembly on one MD-90. The airline discovered that the assembly can be damaged during turns when the airplane is towed by a “supertug,” which does not use a towbar.

“Boeing has advised operators not to use the supertug for towing MD-80, MD-90 and 717 airplanes, and has revised the flight operations manual and aircraft maintenance manual, mandating inspection of the spray deflectors during every ‘A’ check,” the report said.

APU Fails, Ejects Hot Debris Onto Ramp

Boeing 737-500. Substantial damage. No injuries.

The aircraft was parked at a stand and was being prepared for departure from London Gatwick Airport the morning of Sept. 3, 2005, when the commander told the copilot to start the auxiliary power unit (APU). “The passengers had been called for boarding but had yet to reach the aircraft,” the U.K. Air Accidents Investigation Branch (AAIB) report said.

The commander then vacated the flight deck to inspect the cabin and found that the cabin lights were not illuminated. The copilot told him that the APU had automatically shut down. “The flight crew then became aware of a commotion at the rear of the aircraft,” the report said. The aft portion of the aircraft had lurched, and cabin crewmembers believed that it had been struck by a catering truck. However, the commander found that the APU had failed and ejected debris onto the ramp. The commander and the copilot conducted the APU failure checklist.

“Debris was observed extending over some 90 m (295 ft) aft of the aircraft, completely

crossing the taxiway behind the aircraft,” the report said. “Larger items were collected by flight and ground crew and placed below the rear of the aircraft.” The area then was swept clear of debris. No one was injured, and damage was confined to the APU.

The APU’s cast-alloy inflow turbine had failed. “This resulted in vanes separating from the casting as its two liberated halves came into rapid contact with the containment structure,” the report said. “The hot vane debris was ejected through the jet pipe. ... The containment ring was severely deformed ... but had successfully prevented any in-plane departure of turbine debris.”

The report said that nine “broadly similar events” involving APS 2000/2001 APUs occurred between 1999 and 2006. None of the events involved uncontained turbine failures, and no one was injured.

“Efforts have been made to improve the [turbine] manufacturing process, without proven success, and no reliable method has been found to detect the defect in new or existing turbines,” the report said. “No method of establishing a safe in-service life has been determined for this component.”

Baggage Loader Locked in Cargo Hold

Airbus A330-300. No damage. No injuries.

The flight crew had just begun to taxi from the gate for a flight from Dublin (Ireland) Airport to New York the morning of Dec. 28, 2005, when they were told by an airport tower controller that a baggage loader had been accidentally locked in a cargo hold. The crew returned to the gate, and the baggage loader was removed from the airplane.

The Irish Air Accident Investigation Unit (AAIU) report said that while the airplane was being prepared for departure, the baggage loaders were told that one passenger might not be allowed to travel on the flight because of security concerns. The ramp agent asked the loading shift leader to locate the passenger’s baggage, so that it could be unloaded if necessary. While checking the loading cards, the leader noticed that a bag intended for another flight had

inadvertently been loaded into the incident aircraft. The leader told the ramp agent and a member of the loading crew, “Loader 2,” that he was going to retrieve the bag.

While the leader was in the cargo hold, the ramp agent told Loader 2 that the questionable passenger had been cleared by airport security personnel to travel on the flight. Loader 2 relayed the information to two other loading crewmembers but did not tell them that the leader had re-entered the cargo hold. One of the crewmembers gave the “thumbs-up” signal to a colleague, who secured and locked the cargo hold door.

“By this time, the leader had located the [misplaced] bag,” the report said. “However, as the lights remained on in the hold, he did not notice that pushback had commenced. When the engines powered up, he realized that he was locked in. ... He phoned the base supervisors’ office and told them of the situation.”

The incident was classified by AAIU as serious. “[Other] cases have occurred where loaders have been inadvertently locked in a hold,” the report said. “Some years ago, a loader was locked in a hold on a two-hour flight from Philadelphia to Chicago. This was a traumatic event for this person.” Among AAIU recommendations generated by the incident investigation was for the development of standard operating procedures for the late removal of items from cargo holds.

Wind Shifts During Rotation for Takeoff

Boeing 747-400. Substantial damage. No injuries.

Winds were from 180 degrees at 16 kt, gusting to 22 kt, when takeoff was initiated on Runway 10L at San Francisco International Airport for a flight to Hong Kong on Nov. 14, 2003. “The wind shifted during the takeoff roll, resulting in a decreasing headwind, an increasing crosswind and, finally, an average 8-kt tail wind during rotation,” the NTSB report said.

The first officer, the pilot flying, used a significant amount of aileron control to counter the increasing crosswind, which resulted in the right spoiler extending 12 degrees and a corresponding loss of lift. “The combination of the tail

wind gust and spoiler movement resulted in the airplane’s pitch attitude exceeding 12.6 degrees while the landing gear was still on the ground,” the report said.

A few seconds after rotation, the stick shaker activated, and the first officer relieved back pressure on the control wheel. The airport tower controller, who had observed smoke from the airplane when it rotated, told the flight crew that a tail strike might have occurred. The crew returned to the airport and landed the airplane without further incident. None of the 356 occupants was injured. The report said that two of the airplane’s structural members required repair.

Wing Strikes Runway in Freezing Fog

Bombardier CRJ200. Minor damage. No injuries.

The airplane was on initial descent to Rapid City (South Dakota, U.S.) Regional Airport the night of Jan. 17, 2004, when weather conditions were reported as 1.5 mi (2,400 m) visibility, a broken ceiling at 100 ft and an overcast at 500 ft. The flight crew prepared for the instrument landing system (ILS) approach to Runway 32.

The approach controller told the crew that visibility had decreased to 1/4 mi (400 m) in freezing fog, the NTSB report said. The crew requested and received instructions to hold at the outer marker. While holding, the crew was told that visibility had increased to 1/2 mi (800 m); they requested and received clearance to conduct the approach.

“The captain stated that they turned on the [APU] and configured the bleed air system in anticipation of encountering icing conditions when they descended through the fog layer,” the report said. When the airplane entered the fog layer, the crew received an “ICE” warning and activated the wing and engine inlet anti-ice systems. The captain said that he became concerned about the rapid buildup of ice on the windshield wipers. “He stated that he looked out the side window and, although he was unable to tell the quantity, he saw ice accumulating on the winglet,” the report said.

The captain saw the approach lights soon before the airplane reached decision height, and

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the runway came into sight when the airplane was about 140 ft above ground level (AGL). The first officer, the pilot flying, disconnected the autopilot, and the airplane pitched nose-up slightly. The captain told the first officer to keep the nose down and increase thrust. The captain then noticed a decreasing airspeed trend and that the airplane was drifting right of the runway centerline. He took control of the airplane, which he described as feeling “heavy and sluggish” and responding “poorly” to control inputs.

The captain said the left wing dropped and scraped the runway about the same time the left main landing gear touched down. The airplane bounced into the air and landed hard on the runway. None of the 35 occupants was injured. After the airplane was taxied to the gate, the left wing tip was found to have a scrape measuring 3 in by 10 in (8 cm by 25 cm). A portion of the damaged area was abraded to the underlying aluminum structure.

The first officer said that the examination of the airplane also revealed “large amounts of 1/2 to 1 inch [24 to 25 mm] thick, jagged mixed ice all along the vertical and horizontal stabilizers, as well as up the leading edge of the wing tips, and several silver-dollar-size [about 1.6 in (41 mm) in diameter] balls of ice on the static wicks.”

TURBOPROPS

Crew Missed Turn During Approach

Beech C99. Destroyed. Two fatalities.

VMC prevailed at the airport, but instrument meteorological conditions with low visibility in heavy, blowing snow were reported in the area the afternoon of March 18, 2006, when the flight crew of the cargo aircraft began the VOR (VHF omnidirectional radio) approach to Bert Mooney Airport in Butte, Montana, U.S.

The second-in-command (SIC), recently hired by the company, was flying the aircraft from the left seat under the supervision of the pilot-in-command (PIC), the company’s training and check captain, the NTSB report said.

The VOR, the final approach fix, is about 12 nm (22 km) northwest of the airport. The

approach procedure requires a flight to track 127 degrees inbound to the VOR no lower than 7,700 ft, then turn left and track the 097-degree radial to the airport. The minimum descent altitude for the circling approach is 6,900 ft.

The aircraft was in controlled flight at 6,880 ft when it struck mountainous terrain about 9 nm (17 km) southeast of the VOR. The report said that the location of the wreckage indicated that the crew “failed to follow the approach procedure and turn to a heading of 097 degrees after crossing the [VOR].” The course selector in the SIC’s horizontal situation indicator was found set to 127 degrees.

Smoke Prompts Return to Departure Airport

de Havilland Canada Dash 8-200. No damage. No injuries.

The aircraft departed from Melbourne (Victoria, Australia) Airport about 0635 local time on Oct. 19, 2006, for a scheduled flight to Wollongong, New South Wales. The aircraft was climbing through Flight Level 140 about 10 minutes later when the PIC smelled smoke in the cockpit, the Australian Transport Safety Bureau report said.

“Soon afterwards, a smoke detector warning sounded in the aircraft toilet, and the flight and cabin crew observed smoke haze,” the report said. The flight crew reported the situation to ATC (air traffic control) and turned back toward Melbourne. The smoke dissipated after power was reduced for descent. The aircraft was landed without further incident at 0658.

Examination of the Pratt & Whitney Canada PW123D engines disclosed an oil leak in the left engine. “Oil had leaked from several compressor bearings into the low-pressure compressor of the engine,” the report said. “The high temperature of the compressed air and the engine components caused the oil to vaporize, contaminating the air extracted from that engine section to [pressurize and ventilate] the aircraft cabin.”

The engine manufacturer had issued three service bulletins that recommended modifications to prevent this problem. “The operator had already modified about 90 percent [45] of the affected engines in its fleet at the time of the incident,”



the report said. “The operator had planned to modify the remaining engines [including those on the accident aircraft] at the next period of scheduled or unscheduled maintenance.”

Rotating Prop Strikes Runaway Stroller

Saab 340B. Substantial damage. No injuries.

The airplane’s engines had been started in preparation for departure from Alpena (Michigan, U.S.) County Regional Airport for a scheduled flight the night of March 13, 2006, when station agents told the captain that a baby stroller had not been unloaded from the cargo compartment.

The captain shut down the left engine, and a station agent opened and entered the cargo compartment, which is in the left rear fuselage. “While he was exiting the compartment, the station agent lost his balance and dropped the stroller onto the ramp,” the NTSB report said. “The stroller landed on its wheels and was blown under the fuselage by the wind and into the right main landing gear. The stroller was subsequently blown forward into the right propeller arc. ... Fragments from the stroller impacted the airplane’s fuselage, puncturing three holes and causing several dents in the pressurized fuselage.”

There were no injuries to the 14 airplane occupants or the station agent. The report noted that wind velocity was 20 kt, with gusts to 31 kt, when the accident occurred.

Stall Occurs During Practice Engine-Out

Pilatus PC-12/47. Destroyed. Two fatalities.

A local weather-observing station was reporting surface winds from 060 degrees at 17 kt, gusting to 23 kt, when the private pilot and his flight instructor departed from Runway 06 at Big Timber (Montana, U.S.) Airport for a training flight the afternoon of June 24, 2006. Airport elevation is 4,492 ft; temperature was about 73 degrees F (23 degrees C).

The pilot had 725 flight hours, including 140 flight hours in the single-engine PC-12. The flight instructor, a U.S. Air Force pilot, had 3,200 flight hours and previously was employed as a pilot by Pilatus Aircraft.

A witness said that before departing from the 5,287-ft (1,611-m) runway, the pilot announced on the common traffic advisory frequency that he would practice a loss of engine power after takeoff and conduct a 180-degree turn back to the airport.

“Another witness said that [after liftoff] the airplane pitched up 30 degrees while simultaneously banking hard to the right in an uncoordinated manner,” the report said. The airplane stalled, rolled right and pitched nose-down. The witnesses said that the wings then were leveled and the pilot appeared to be recovering from the dive and flaring the airplane to land in an open field near the runway. However, the left wing tip struck a large rock and a fence post, and the airplane crashed and was consumed by fire.

“No preimpact engine or airframe anomalies which might have affected the airplane’s performance were identified,” the report said.

PISTON AIRPLANES

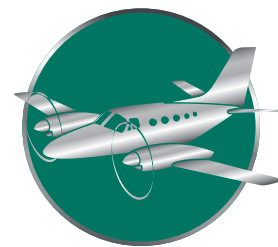
Fuel Exhaustion Leads to Ditching

Beech 18. Substantial damage. No injuries.

The pilot, who had 34,450 flight hours, including 14,150 flight hours in Beech 18s, was hired by the new owner of the airplane to fly it from Antigua to Puerto Rico on Aug. 8, 2006. The airplane had not been flown in 12 years.

“The initial test flight [by the pilot on Aug. 5] revealed some discrepancies, including high fuel pressure on the right engine and a strong smell of gasoline fumes inside the airplane,” the NTSB report said. The pilot said that when he returned to conduct the delivery flight, he was told that repairs had been made and that the airplane had received an annual inspection.

The pilot said that he departed with three hours of fuel for the 253-nm (469-km) flight. About 1.5 hours after departure, the airplane was in cruise flight at 6,500 ft, about 40 nm (74 km) from Puerto Rico, when the pilot noticed a strong odor of fuel. Both engines lost power soon thereafter. The pilot turned toward the island of Culebra, Puerto Rico.



“He kept the propellers windmilling while he performed emergency procedures by switching fuel tanks and attempting to restart the engines,” the report said. “The pilot noted that he was unable to cross-feed fuel because the valve handle would turn 360 degrees without operating properly. He also noted that there was no fuel pressure, and the fuel gauges indicated empty.”

The pilot feathered the propellers and ditched the airplane near the shoreline. Both occupants exited with a life raft before the airplane sank in about 50 ft (15 m) of water.

NTSB said that the probable cause of the accident was “a loss of engine power due to fuel starvation/exhaustion in all engines for an undetermined reason.”

Thunderstorm Triggers Control Loss

Piper Aztec. Substantial damage. Three fatalities.

Soon after departing from Abaco Island, Bahamas, the afternoon of June 20, 2005, the commercial pilot obtained an ATC clearance to proceed under instrument flight rules (IFR) to Fort Pierce, Florida, U.S.

The airplane was in cruise flight at 10,000 ft when information about convective activity along the pilot’s route of flight was broadcast on the ATC radio frequency. “However, both controllers [who communicated with the pilot] stated that they observed precipitation returns in the vicinity of the airplane’s route but never advised the pilot of those observations.”

About an hour after obtaining the IFR clearance, the pilot told ATC that the airplane was in severe turbulence and requested help in navigating out of the weather. The controller told him that the airplane was in an area of heavy precipitation and “should be exiting at any moment,” the report said. Investigators believe that soon thereafter, the pilot lost control of the airplane, which then struck the water. The airplane and the three occupants were not found. “The pilot and two passengers are presumed dead, and the airplane is presumed to have sustained substantial damage,” the report said.

NTSB said that the probable cause of the accident was “the pilot’s continued flight into

known thunderstorm activity” and that a factor was “the controllers’ failure to provide the pilot with [information about] convective intensity.”

Loose Fuel Fitting Cited in Engine Fire

Piper Chieftain. Substantial damage. No injuries.

One of the six passengers on the commuter flight noticed the odor of gasoline and smoke as the airplane was being turned onto final approach to land at Elim, Alaska, U.S., the afternoon of May 9, 2005. During the landing roll, the pilot saw a fire in the right engine compartment.

“He pulled the firewall fuel shutoff for the right engine and stopped the airplane,” the NTSB report said. The passengers were evacuated, and the pilot and airport personnel extinguished the fire. Examination of the engine revealed that the fire was concentrated around the hydraulic pump, fuel pump and turbocharger. A B-nut fitting on the fuel pump was found loose.

The report noted that the hydraulic pump had been replaced about 31 hours before the accident flight. Maintenance personnel had removed the fuel pump to gain access to the hydraulic pump. “Due to the confined area during the reinstallation of the feeder line to the fuel pump, one mechanic held the line in place and another turned the fitting with a wrench,” the report said. “A leak check revealed that the fitting was cross-threaded and leaking. The fitting was retightened and signed off.”

NTSB said that the probable cause of the accident was improper installation of the fuel line fitting.

HELICOPTERS

Carburetor Ice Suspected in Power Loss

Robinson R22 Beta. Substantial damage. One serious injury.

The pilot was preparing to return to his home base after providing sightseeing flights for interns at an avian rescue organization near Courtenay, British Columbia, Canada, on June 24, 2005. After starting the engine and re-engaging the clutch, he operated the power plant for about two minutes before takeoff, said the report by the Transportation Safety Board of Canada.



“The pilot lifted off, turned the helicopter 180 degrees to point toward his departure path and raised collective to perform a confined-space takeoff,” the report said. About 60 ft AGL, abnormal engine sounds and “an apparent detonation” were heard. The helicopter descended rapidly while turning 270 degrees left and struck the ground.

“The Robinson R22B helicopter’s low-inertia rotor design is susceptible to rapid loss of rotor rpm if mishandled, and quick recovery action is required by the pilot,” the report said. “In this occurrence, when the engine stopped, there was little airspeed or altitude to be traded for energy to the rotor system.”

The report said that the weather conditions, which included a temperature of 19 degrees C (66 degrees F) and a dew point of 12 degrees C (54 degrees F), were conducive to the formation of carburetor ice, which typically is detected by a decrease in manifold pressure and engine rpm. However, the R22B pilot’s operating handbook states that these indications might not be noticed because the engine governor automatically adjusts the throttle to maintain constant manifold pressure and rpm.

The helicopter was equipped with a carburetor temperature gauge. The pilot told investigators that he did not recall applying carburetor heat before departure or during the takeoff.

Whiteout Encountered During Air Tour

Bell 206L-1. Substantial damage. Three minor injuries.

The pilot was conducting an air tour on May 31, 2006, over glaciers and mountainous terrain in an area near Juneau, Alaska, U.S., that had fog, whiteout conditions and flat light conditions, the NTSB report said.

The pilot told investigators that he could not see the ground while maneuvering over a glacier. A passenger said that it was “all white” outside when the helicopter struck terrain. The pilot and two passengers received minor injuries; four passengers were not injured.

NTSB said that following a series of similar helicopter accidents, it recommended in 2002

that the U.S. Federal Aviation Administration (FAA) require radio altimeters aboard all commercial, passenger-carrying helicopters operated in areas conducive to flat light and whiteout conditions. The FAA replied that a radio altimeter would be ineffective in preventing such accidents unless it was accompanied by all the other instruments required for IFR flight. NTSB said that the FAA’s response was unacceptable and that the recommendation, A-032-35, remained open.

Student Pilot Makes Premature Solo Flight

Robinson R44. Substantial damage. No injuries.

During a training exercise at Denham (England) Airfield on Oct. 16, 2006, the flight instructor briefed the student on engine-start procedures and allowed the student to start the engine while alone at the controls. “The instructor had intended to board the helicopter after the engine was started, and with the rotors running,” the AAIB report said.

The student, who had received seven hours of flight instruction in the R44, started the engine without difficulty but continued the “Starting Engine and Run-Up” checklist beyond the point briefed by the instructor. “The final item in the checklist was to set the rotor rpm to between 101 and 102 percent, then lift the collective lever and reduce the rpm in order to check operation of the low-rotor-rpm warning light and horn at 97 percent,” the report said. “As the student lifted the collective lever, the helicopter began to move, and the student’s response resulted in violent control inputs which led to the tail boom being severed by the main rotor.”

The report said that as a result of this accident and a similar accident that occurred in October 2003, the U.K. Civil Aviation Authority added the following requirement, article 50(4), to the Air Navigation Order: “An operator shall not permit a helicopter rotor to be turned under power for the purpose of making a flight unless there is a person at the controls entitled in accordance with article 26 of this Order to act as pilot-in-command of the helicopter.” ●

Preliminary Reports

Date	Location	Aircraft Type	Aircraft Damage	Injuries
May 1, 2007	Peterborough, England	Eurocopter AS 355F2	substantial	4 fatal
The helicopter was en route from Liverpool to a private landing area near Peterborough when it struck terrain at 2330 local time.				
May 2, 2007	Atlanta, Georgia, U.S.	McDonnell Douglas DC-10-30	none	306 none
During a flight from Ireland, the airplane was descending to land when the flight crew declared an emergency because of a malfunction of the horizontal stabilizer trim system. The crew had received an out-of-trim warning before the autopilot disengaged and the airplane pitched nose-down. The crew said that a “demanding amount” of elevator back-pressure was required to maintain level flight, but they were able to land the airplane without further incident. Initial examination disclosed a fractured shear pin in the stabilizer chain drive unit.				
May 3, 2007	Dillon, Montana, U.S.	Cessna Citation S550	destroyed	2 fatal
Visual meteorological conditions prevailed when the airplane struck terrain about 1/4 mi (402 m) from the runway during a VOR (VHF omnidirectional radio) approach at 1040. Witnesses heard abnormal engine noises and saw the airplane make several turns of decreasing radius before the accident occurred.				
May 5, 2007	Douala, Cameroon	Boeing 737-800	destroyed	114 fatal
The airplane struck terrain soon after departing from Douala at 0050 for a flight to Nairobi, Kenya. Adverse weather conditions were reported in the area.				
May 9, 2007	London, England	Dassault Falcon 20	none	7 none
En route from Gander, Newfoundland, Canada, the airplane was on approach to London Stansted Airport at 2205 when the crew declared an emergency and reported that the flight controls were locked. The airplane was landed without further incident about 20 minutes later.				
May 10, 2007	Pointe Noire, Congo	Ilyushin IL-76TD	destroyed	none
A fire erupted in the cargo airplane as it was being loaded in preparation for a flight to Brazzaville.				
May 11, 2007	Gulf of Mexico	Bell 206B	substantial	2 minor, 2 none
The pilot said that the helicopter entered an uncommanded descent and began rotating right when he attempted to transition from a hover to forward flight on departure from an offshore platform. He deployed the emergency floats before the aircraft struck the water.				
May 13, 2007	London, England	Boeing 737-800	none	176 none
A partial, temporary loss of flight displays occurred soon after the airplane departed for a flight to Stockholm, Sweden, at 1129. The crew declared an urgency, returned to London Stansted Airport and landed the airplane without further incident.				
May 17, 2007	Walikale, Democratic Republic of Congo	LET 410	destroyed	3 fatal
A fire erupted in an engine soon after departure for a cargo flight to Goma. The crew was attempting to return to the airstrip when the airplane crashed in a forest.				
May 18, 2007	Syracuse, New York, U.S.	Douglas DC-9-31	substantial	99 none
The cabin depressurized as the airplane was climbing through 19,000 ft after departing from Syracuse. The crew diverted to Buffalo and landed without further incident. A 12-in by 5-in (30-cm by 13-cm) tear in the fuselage skin was found forward of the forward cargo door. The preliminary report indicated that the damage may have been caused by a baggage-cart tug.				
May 23, 2007	Warraber Island, Queensland, Australia	Piper PA-32-260	destroyed	4 NA
During a charter flight from Horn Island to Warraber Island, the pilot reported engine problems and subsequently ditched the airplane. The four occupants were rescued by a helicopter crew.				
May 24, 2007	Pampa Hermosa, Peru	de Havilland Canada DHC-6	destroyed	13 fatal, 7 serious
The Twin Otter struck mountainous terrain during a charter flight from Orellana to Pampa Hermosa.				
May 30, 2007	McGrath, Alaska, U.S.	Carvair ATL-98	substantial	2 none
The cargo airplane, a modified Douglas DC-4, crashed while landing with a tail wind on a 4,200-ft (1,280-m) gravel runway.				

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.