Right Layout, Wrong Airport

The A320 pilots were convinced that they had their destination in sight.

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 on aircraft accidents and incidents by official investigative authorities.

JETS

Airplane Landed at a Military Airfield

Airbus A320. No damage. No injuries.

The aircraft was being operated on a scheduled flight with 39 passengers and six crewmembers from Liverpool, England, to Londonderry-Eglinton Airport (LDY) in Northern Ireland the afternoon of March 29, 2006. Nearing LDY from the east in visual meteorological conditions, the flight crew was cleared by air traffic control (ATC) to conduct the ILS/DME (instrument landing system/distance measuring equipment) approach to Runway 26, said the U.K. Air Accidents Investigation Branch (AAIB) report.

During the approach, the crew mistook Balleykelly Airfield (BKL) for LDY. BKL, a former Royal Air Force airfield used primarily to support British Army helicopter operations, is 5 nm (9 km) east-northeast of LDY and slightly north of the LDY Runway 26 localizer course. The airports have similar runway layouts, and the crew flew the aircraft toward Runway 26 at BKL.

The crew's navigation charts, obtained from a commercial vendor, did not show a runway diagram for BKL. The report noted that charts produced by another commercial vendor show a runway diagram for BKL with the notation: "Do not mistake Ballykelly apt for Londonderry-Eglinton."

"Not being aware that there was another airfield in the vicinity with a very similar layout and misbelieving the (correct) ILS glideslope and DME indications, the crew continued towards the only airfield they could see, firmly convinced that they were landing at LDY," the report said.

The crew told ATC, "The ILS isn't really giving us decent glide path information. We're [going to] make a visual approach from here. We're showing eight [DME], but it looks a bit less than that." The controller cleared the crew for a visual approach and told them to "report on a four-mile final."

The commander disconnected the autopilot and increased the aircraft's rate of descent. "The A320 crew then asked that, if they had to fly a missed approach, could they join the visual circuit downwind," the report said. "ATC informed them that it would be a right-hand circuit and added that there was also a rain shower approaching from the northwest." The crew, still believing that Runway 26 at BKL was their landing runway, decided that the aircraft was too

high to be landed safely and informed ATC that they were going around and would enter the pattern on right downwind.

A railway line passes close to the approach threshold of Runway 26 at LDY, "and aircraft inbound to this runway are sequenced to avoid trains," the report said. ATC told the A320 crew to keep their pattern "reasonably tight" so that the aircraft could be landed before a train arrived in about eight minutes.

"Without changing configuration or pressing the go-around buttons on the thrust levers, and after having re-engaged the autopilot, the A320 crew started a descending 360-degree turn and repositioned onto the right base leg for a visual approach to Runway 26," the report said.

"It was the wrong airport. You've landed at Ballykelly."

The crew reported a two-mile final, and the LDY tower controller, who had the aircraft in sight, cleared the crew to land. The aircraft was 384 ft above ground level (AGL) when the terrain awareness and warning system (TAWS) generated a "GLIDESLOPE" warning and a "TERRAIN AHEAD" warning. "Due to the distracting nature of this warning, the copilot attempted to silence it by pressing the 'TERR OFF' button in the overhead panel," the report said.

About 30 seconds later, the controller told the crew to report their position. The crew replied, "We've just touched down." The controller said, "It was the wrong airport. You've landed at Ballykelly." The controller then told the crew to remain on the ground. The crew turned the aircraft around on the runway and shut down the engines. The passengers and baggage were transported to LDY by ground vehicles. The aircraft departed from BKL that evening with only a crew aboard.

Abrupt Pull-Up Injures Flight Attendant

Canadair Challenger. No damage. One serious injury.

The airplane was on a fractional-ownership operation positioning flight from Chattanooga, Tennessee, U.S., to Augusta, Georgia, the night of May 21, 2005. ATC told the flight crew to expedite their climb through Flight Level 250 (approximately 25,000 ft), and the copilot, the pilot flying, adjusted the selected airspeed to 300 kt, apparently to increase the rate of climb. The pilot-in-command (PIC) then told the copilot to "get this thing climbing."

"At the same time, the PIC pulled back on the control column and disconnected the autopilot, and the nose of the airplane pitched up," said the U.S. National Transportation Safety Board (NTSB) report. "The PIC did not establish a positive transfer of the flight controls as required by company standard operating procedures."

The pilots then heard the flight attendant calling for help. "The PIC departed the flight deck and found the flight attendant on the floor in the aft part of the cabin with serious injuries," the report said. "The flight continued to the destination airport and landed without further incident."

Vehicle Parked in Prohibited Ramp Area

Boeing 737-400. Substantial damage. No injuries.

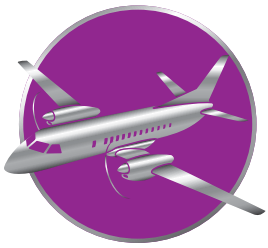
The airplane was being taxied to its assigned parking stand at London Heathrow Airport on Feb. 20, 2006, when the right wing struck a vehicle — a van — that was parked in a prohibited area. The wing tip was crushed, and the navigation and strobe lights were destroyed. None of the 95 occupants of the airplane or the van driver was injured. Damage to the vehicle was relatively minor, said the AAIB report.

"The member of the ground staff whose responsibility it was to ensure that the stand was unobstructed was unable to see the whole stand from his assigned position in the jetty [airbridge]," the report said. "Members of the ground staff who saw the potential conflict were unable to alert the pilots." The pilots did not see their hand signals, and none of the ground staff was near a button that can be used to illuminate an emergency-stop signal visible at the end of the stand.

The van driver had stopped the vehicle in the prohibited area, which was marked with hatched lines, to make way for other employees of the handling agent who were maneuvering baggage carts in the same area. "He kept the engine of the van running and, aware that the aircraft was approaching, intended to return to

the non-hatched area as soon as the baggage trolleys were in place," the report said. "He was unable to do so before the aircraft hit the van."

The pilots were aware that the van had been parked incorrectly but did not believe that it would be an obstacle. "This would have been the case if the aircraft had been lined up on the stand centerline before entering the stand," the report said. "However, the commander, aware of the confined nature of the stand, made a tighter turn onto the stand than that indicated by the lead-in line painted on the ground and remained at all times to the right of the stand centerline."



TURBOPROPS

Hydraulic Fluid Leaks Into Cabin

British Airways ATP. Minor damage. No injuries.

Soon after the aircraft departed from Ronaldsway Airport on the Isle of Man for a scheduled flight to Liverpool, England, the evening of May 23, 2005, a hydraulic seal in the front left cabin door failed. "This allowed hydraulic fluid to escape [into the cabin] in the form of a fine mist, depleting the contents of the main hydraulic system," the AAIB report said.

The no. 2 cabin crewmember, who was seated in the forward section of the cabin, heard what she described as "a burst and then the sound of escaping gas" that smelled like turpentine and saw what she thought was smoke emerging from the door. She attempted unsuccessfully to use the public-address system to attract the attention of the no. 1, senior, cabin crewmember, who was seated in the rear of the cabin. She then used the interphone system to tell the commander, "I've got a bit of … smoky stuff coming through the door." The commander began to ask a question but was interrupted by the no. 1 cabin crewmember, who stated, "Smoke in the cabin."

The flight crew then received a visual and aural warning that the hydraulic-fluid quantity was at a low level. They began conducting, but did not complete, the "Low Hydraulic Quantity" checklist. The crew did not conduct the "Fire, Smoke or Fumes Within Fuselage" checklist, which calls in part for donning oxygen masks and smoke goggles.

The commander, the pilot monitoring, reported "a minor problem" to ATC and requested, and received, clearance to return to Ronaldsway Airport. The commander then told the controller, "We'd just like to make this a pan. We have reports of a little bit of smoke in the cabin. We have got a hydraulic-low-level warning on the system."

The misting intensified, and the cabin crew moved passengers seated in the forward section of the cabin to the rear of the cabin. The no. 1 cabin crewmember informed the commander that the smoke was so thick in the forward cabin section that visibility was impaired. Some passengers used airsickness bags and other materials as filters to aid their breathing. One passenger had trouble breathing and was administered oxygen.

Hydraulic fluid mist had begun to enter the flight deck. The commander selected the environmental conditioning system packs off, "the opposite action to that called for in the checklist," the report said. The commander told the controller, "We've got slightly more smoke in the cockpit now, so we'd like to make this into a mayday, please." The copilot asked the commander if the smoke might be related to the hydraulic system problem. The commander said that he did not know.

"The flight crew's nonadherence to SOPs [standard operating procedures] and associated checklists put the aircraft and its occupants at unnecessary increased risk from potential handling problems as well as risk of fire and prolonged exposure to hydraulic fluid mist," the report said.

The pilots acquired visual contact with the runway while conducting an ILS approach. Soon after the aircraft reached the decision altitude, a TAWS "TOO LOW, TERRAIN" warning and a "TOO LOW, FLAPS" warning were generated. The commander dismissed both warnings as false. "However, he then realized that the flaps had not been set for landing and that this latter warning was genuine," the report said. "The warnings ceased after flaps 20 was selected."

After landing, as the aircraft decelerated through 80 kt, the copilot transferred control to the commander, who had difficulty steering

The no. 1 cabin crewmember said that some passengers were panicking and others were nauseous.

the aircraft with the tiller. Recognizing that the nosewheel-steering system was not functioning, he used differential braking and asymmetric thrust to maneuver the aircraft onto a taxiway.

The no. 1 cabin crewmember said that some passengers were panicking and others were nauseous. The copilot asked the commander if they should shut down the engines. The commander replied that he intended to continue taxiing. Then, however, the controller said, "You might just as well shut down in that position there." The report said that the controller wanted aircraft rescue and fire fighting (ARFF) vehicles to catch up with the aircraft.

After shutting down the engines, the commander "realized there was a slippery substance on the flight deck floor and deduced that it was hydraulic fluid," the report said. "He inspected the area around the airstairs, concluding that the fluid had come from this region and that this was associated with the hydraulic fluid low level warning. The passengers left the aircraft via the forward vestibule and the airstairs, passing through the contaminated area." ARFF personnel assisted the evacuation.

None of the four crewmembers or 33 passengers was injured. "One passenger, who was asthmatic, was taken to a local hospital but later discharged as medical treatment was not considered necessary," the report said. The crew and passengers completed the flight to Liverpool in another aircraft.

The broken hydraulic seal was in an airstairs-retraction-line fitting. The line normally is not pressurized during flight. However, the plastic guard for the push-button switch used to retract the airstairs had been lifted beyond its 90-degree limit of movement. The upper edge of the guard that extends between its pivot points had contacted the switch and held it in place. The report said that after a 1989 incident involving an uncommanded airstairs retraction during preflight inspection of an ATP, balk strips had been attached to the plastic guards in ATPs to prevent them from being lifted beyond their normal range of movement. Traces of adhesive on the incident aircraft's plastic guard indicated that a balk strip "had been present at some stage and that [it] had most probably been broken off as a result of the guard being forced beyond the 90-degree position," the report said. In addition, the door safety microswitch plunger had become stuck in its retracted position, allowing electrical power to be routed to the door-retraction circuit. After investigators cleaned and adjusted the microswitch in accordance with the aircraft maintenance manual, it operated normally.

The report said that the combination of the jammed retraction switch and the stuck microswitch plunger allowed the hydraulic airstairs actuator-retraction line to remain pressurized. "The reason for the failure of the seal was not established but could have been the result of … insufficient assembly torque or degradation of the seal material," the report said.

Runway Excursion Reflects Lack of CRM

Beech Super King Air B300. Substantial damage. No injuries.

The aircraft departed from Saint-Hubert, Quebec, Canada, for a flight to Saint-Georges with the two pilots and the company president aboard the morning of Dec. 1, 2004. About 10 minutes after takeoff, the PIC, the pilot monitoring, advised the Unicom operator at the Saint-Georges airport that the aircraft would arrive in about 20 minutes, said the report by the Transportation Safety Board of Canada.

The Unicom operator told the PIC that the winds were from the east at 4 kt and the altimeter setting was 29.65 in Hg. The airport did not have equipment or procedures for reporting other weather conditions. The Unicom operator then initiated snow-removal operations on Runway 06/24, which was 5,100 ft (1,556 m) long and 75 ft (23 m) wide.

The Montreal Center controller told the crew that current conditions in Quebec included a vertical visibility of 500 ft and a horizontal visibility of 1/2 mi (800 m) in snow. The controller then cleared the crew to conduct an approach to the Saint-Georges airport, which is in uncontrolled airspace.

While conducting a global positioning system (GPS) approach to Runway 06, the crew was

told that the runway had been cleared of snow to a width of 36 ft (11 m). The aircraft was about 0.75 nm (1.39 km) from the runway threshold when the PIC told the copilot that he had the runway lights in sight and that there might be a snowplow on the runway. The report said that both altimeters were set to 29.55 in Hg, rather than the reported 29.65 in Hg, and thus indicated altitudes 100 ft lower than the aircraft's actual altitudes. The PIC determined that the aircraft was too high to be landed safely; he assumed control and began a go-around.

The pilots had not briefed the missed approach and did not follow the published missed approach procedure. Instead, the PIC flew the runway heading, "then followed a path that led [the aircraft] six minutes later to a point 18 nm [33 km] north of the runway," the report said. The pilots did not brief the second approach, a GPS approach to Runway 24. The PIC set the altitude selector to 1,100 ft — 200 ft below the published minimum descent altitude (MDA) — and the radio altimeter to 380 ft, the height above airport (HAA) at the MDA.

The report said that the weather conditions deteriorated significantly in heavy snow during the approach. The aircraft was 0.25 nm (0.46 km) from the airport when the copilot saw the runway to the right. "The [PIC], who could not see the runway, followed the copilot's directions," the report said. "The aircraft followed a zigzag path and flew over the [precision approach path indicator lights], the runway centerline and the right-side runway lights, then turned left again. The [PIC] saw the runway and landed."

The King Air likely was drifting left when it touched down 2,400 ft (732 m) from the approach threshold. The left main landing gear, then the nose landing gear struck a 12-in (30-cm) snow bank. The nose gear strut broke, and the aircraft turned left, overran the left side of the runway and came to a stop nose-down in a drainage ditch.

The report said that the PIC, who had about 4,500 flight hours, had little experience flying as a member of a crew before he was employed by the company in July 2004. Neither the PIC nor the copilot, who had about 1,200 flight hours, had received crew resource management (CRM) training, "which could explain their noncompliance with procedures and regulations," the report said.

Unstabilized Approach Leads to CFIT

Mitsubishi MU-2B-60. Destroyed. One fatality.

The pilot was conducting an on-demand cargo flight from Salt Lake City to Centennial Airport near Denver the night of Aug. 4, 2005. Weather conditions included 2.5 mi (4,000 m) visibility in rain and mist, a broken ceiling varying in height from 600 ft to 1,300 ft and surface winds from 010 degrees at 8 kt, the NTSB report said.

The airplane was about 10 nm (19 km) from the airport about 0204 when the approach controller cleared the pilot for an ILS approach to Runway 35R and told him to establish radio communication with the tower controller. The tower controller cleared the pilot to land on Runway 35R.

Recorded ATC radar data indicate that the MU-2 was 774 ft below the glideslope when it crossed the final approach fix. The report said that the airplane tracked the localizer course but continued a controlled descent below the glideslope until it struck terrain about 4 nm (7 km) from the runway threshold at 0206.

The airplane tracked the localizer course but continued a controlled descent below the glideslope until it struck terrain.

NTSB said that the pilot's "failure to fly a stabilized instrument approach at night" was the probable cause of the controlled flight into terrain (CFIT) accident and that "inadequate design and function of the airport facility's minimum safe altitude warning (MSAW) system" were among the contributing factors.

The approach controller received visual and aural MSAW alerts for about five seconds when the MU-2 was 7.2 nm (13.3 km) from the airport and again when the airplane was 6.3 nm (11.7 km) from the airport. The approach controller did not inform the tower controller of the MSAW alerts because she believed, erroneously, that the tower controller also was receiving visual and aural alerts on the MU-2. The report said that she was not aware that, because of

the MSAW system design, the tower controller would receive visual alerts but not aural alerts until the airplane was within 5 nm (9 km) of the airport (*ASW*, 2/07, p. 33).

The tower controller apparently did not see the visual MSAW alerts on his radar display when the MU-2 was 7.2 nm and 6.3 nm from the airport. "A tower controller does not utilize a radar display as a primary resource for managing air traffic," the report said.

The tower controller received an aural MSAW alert when the MU-2 was 5 nm from the airport and immediately told the pilot to "check altitude … you appear to be well below the glideslope." There was no response from the pilot, and the airplane struck terrain a few seconds later.

PISTON AIRPLANES

Icing, Turbulence Cause Loss of Control

Cessna T310R. Destroyed. One fatality.

The airplane was in cruise flight at 16,000 ft near Heber City, Utah, U.S., the morning of April 17, 2006, when manifold pressure in the left engine decreased due to induction-system icing. The pilot requested a lower altitude and was cleared by ATC to descend to 14,000 ft, said the NTSB report. No further radio transmissions were received from the pilot, and ATC radar contact was lost when the airplane descended below 11,400 ft. NTSB determined that the pilot likely lost control of the airplane.

"The wreckage was located [at 9,350 ft] in mountainous, down-sloping, snow-covered, forested terrain," the report said. "Based on area forecasts, PIREPS [pilot reports] and weather advisories, the accident airplane most likely encountered moderate to severe turbulence and moderate to severe mixed icing during the final few minutes before the accident."

Broken Bolt Fouls Nose Landing Gear

Beech B58 Baron. Substantial damage. No injuries.

The pilot said that he completed the landing checks during a visual approach to Runway 27 at Guernsey (Channel Islands, U.K.) Airport the morning of July 4, 2006. After a normal touchdown, the pilot heard a loud bang as the nosewheel was lowered onto the runway, said the AAIB report. The landing gear warning horn then sounded, and the gear-unsafe warning light illuminated.

"Up elevator and go-around power were both applied, and during the subsequent go-around, it could be seen in the mirror on the left engine cowling that the nose leg was swinging free and unlocked," the report said. "A hold was carried out to the south of the airport, where a partial retraction, followed by gear extension using the manual emergency system, was carried out. The nose leg remained in the same position throughout this procedure."

The pilot then conducted another approach to Runway 17. When the main landing gear touched down, he selected the engine fuel/air mixture levers to "CUT OFF" and selected the magnetos to "OFF." Both propellers, the engine mounts and the bottom of the forward fuselage were damaged during the landing.

"Subsequent examination of the aircraft by the repair company revealed that a bolt locating a drive rod operating the drag brace had sheared, thus affecting the geometry [of the nose landing gear]," the report said. "As a result, the normal overcentering action could not take place during the gear-extension phase, and the nose leg could not be locked down."

Oil Pump Failure Prompts Forced Landing

Cessna P210N. Destroyed. One fatality, one serious injury.

Soon after departing from Amarillo, Texas, U.S., for a business flight the morning of July 19, 2006, the pilot told ATC that a cylinder had separated from the engine and that he needed to proceed to the nearest airport. The controller provided a heading toward an airport 7 nm (13 km) away and advised of landmarks that could help the pilot locate the runway, said the NTSB report.

Before reaching the airport, however, the pilot reported a total loss of power and that he was going to land the airplane on a field. The landing was conducted with a tail wind, and the airplane struck a barbed-wire fence, a tractor

and a water well, came to a stop next to a large propane tank and began to burn. "As a result of the extreme heat associated with the post-impact fire, the tank's safety relief valve popped (as designed), which released propane vapors into the air," the report said. "These vapors caught on fire and added to the intensity of the fire." The passenger was seriously injured, and the pilot died of his injuries several days after the accident.

While examining the engine, investigators found a breach in the crankcase and signs of thermal distress on the crankshaft and connecting rods consistent with lack of lubrication. Disassembly of the oil pump revealed that the engine-driven gear shaft had fractured because of wear associated with the absence of support bushings. NTSB said that the probable cause of the accident was "the failure of maintenance personnel to install oil pump support bushings."

The engine had been operated 1,060 hours since overhaul in July 1998 and 460 hours since repairs were performed after a propeller strike in March 2000. The company had not retained, and was not required to retain, records for the overhaul or repairs. "As a result, it could not be determined when/who had last disassembled/reassembled the pump," the report said.

HELICOPTERS

Wrong Performance Chart Used for Takeoff

Bell 206L. Substantial damage. Six minor injuries.

The helicopter was near its maximum gross weight, and density altitude was about 10,200 ft when the pilot attempted to take off from a remote landing zone about 60 nm (111 km) southeast of Vernal, Utah, U.S., for a charter flight on June 15, 2006. The NTSB report said that the pilot had consulted performance data in the "Hover Ceiling In Ground Effect" chart, which indicated that the helicopter could safely depart.

"Because he was taking off over uneven, sloping, brush-covered terrain, he should have used the 'Hover Ceiling Out of Ground Effect' chart, which indicated the helicopter did not have the performance to safely depart the landing zone," the report said.

After lifting off and transitioning into forward flight, the pilot increased power and applied right anti-torque control to climb above brush on rising terrain. "When he applied the right anti-torque pedal, the helicopter's heading rotated about 45 degrees to the right, but it did not climb any higher," the report said. The pilot attempted a precautionary landing on a road, but a loss of tail rotor effectiveness occurred. The helicopter spun once, descended, struck the ground in a nose-low attitude and rolled onto its side.

Sightseeing Flight Ends in River

Agusta-Bell 412. Destroyed. One fatality, three serious injuries, one minor injury.

The pilot was scheduled to conduct a post-maintenance positioning flight in the commercial helicopter from Seville, Spain, to Malaga the morning of Nov. 14, 2004. He invited four acquaintances to accompany him on a 30-minute local flight before he began the positioning flight, said the report by the Spanish Civil Aviation Accident and Incident Investigation Commission.

After departing from Seville's La Cartuja Heliport, the pilot flew the helicopter 100 ft above a river on approach to Tablada Airport, about 2.5 nm (4.6 km) south of the heliport. Nearing the runway, the helicopter flew over a bridge and began a descent that continued for 10 seconds until it struck the water and sank. "Moments later, four of the occupants emerged to the surface and were picked up by a boat downstream from the crash site," the report said. "A fifth person [a passenger] remained underwater."

The report said that before the accident occurred, the pilot might have been distracted by his passengers and by paragliding activity at the airport, and that he likely became spatially disoriented while flying the helicopter low over the "glassy" — still and featureless — surface of the river. ●

Preliminary Reports

Date	Location	Aircraft Type	Aircraft Damage	Injuries
Jan. 1, 2007	Makassar, Indonesia	Boeing 737-400	destroyed	102 fatal
The Adam Airlines flight was en route at 35,000 ft from Surabaya to Manado when ATC radar contact was lost about 60 nm (111 km) from Makassar. The airplane is believed to have crashed at sea.				
Jan. 5, 2007	Matabwe, Tanzania	Piper Chieftain	destroyed	1 fatal, 1 serious, 9 minor
During a charter flight from Dar es Salaam, the pilot rejected the landing after the airplane touched down about halfway down the wet 2,300-ft (702-m) runway at Matabwe. The airplane struck trees beyond the end of the runway and caught fire.				
Jan. 5, 2007	Denver, Colorado, U.S.	Airbus A319	none	none
The Frontier Airlines airplane was on final approach when the flight crew saw a Swearingen Metroliner on the runway. The crew initiated a go-around, and the A319 passed about 50 ft over the Key Lime Air Metroliner. Visibility was 1/2-mi (800-m) with blowing snow and mist.				
Jan. 7, 2007	Sandy Bay, Saskatchewan, Canada	Beech A100 King Air	NA	1 fatal, 3 serious
The airplane was on an emergency medical services flight when it struck terrain during a nonprecision approach. The captain was killed; the first officer and two medical crewmembers were seriously injured.				
Jan. 9, 2007	Balad, Iraq	Antonov An-26B	destroyed	34 fatal, 1 serious
During a charter flight from Adana, Turkey, the flight crew conducted a missed approach at Balad Air Base because of fog. On the second approach, the airplane struck terrain 2.5 km (1.4 nm) from the runway.				
Jan. 9, 2007	Guadalajara, Mexico	Learjet 24F	destroyed	2 fatal
The airplane was on a night cargo flight from Laredo, Texas, U.S., when it struck a hill during descent 13 nm (24 km) from Miguel Hidal Airport.				
Jan. 9, 2007	Kenai, Alaska, U.S.	Cessna 207A	substantial	1 fatal
The pilot ditched the airplane in Cook Inlet after the engine failed during a cargo flight. The airplane was found partially submerged in 50 ft of water. The pilot, who was not wearing flotation gear, was not found.				
Jan. 12, 2007	Van Nuys, California, U.S.	Cessna CitationJet	destroyed	2 fatal
Soon after takeoff for a positioning flight to Long Beach, the crew requested and received clearance to return to the Van Nuys airport. Witnesses said that the left front baggage door was open. The airplane was about 200 ft AGL when it turned left, began to descend with the wings rocking, and then turned right before crashing on a street.				
Jan. 13, 2007	Valledupar, Colombia	Rockwell Commander 690A	destroyed	4 fatal
Soon after the pilot reported technical problems to ATC, the airplane struck mountainous terrain.				
Jan. 13, 2007	Kuching, Malaysia	Boeing 737-200	destroyed	4 NA
The airplane was on a night cargo flight from Kuala Lumpur when it overran the side of the runway at Kuching. The left engine and main landing gear separated before the airplane came to a stop in a grassy field.				
Jan. 15, 2007	Adjuntas, Puerto Rico	Partenavia P68C	destroyed	2 fatal
Nighttime visual meteorological conditions prevailed when the airplane, which was en route from Aguadilla to Ponce, struck trees and crashed on a mountain slope.				
Jan. 17, 2007	Nenana, Alaska, U.S.	Douglas DC-4	destroyed	2 none
The airplane was on a cargo flight from Fairbanks to Nixon Fork Mine when one engine caught fire. The flight crew diverted toward Nenana Airport but was forced to land the airplane on tundra 5 nm (9 km) from the airport.				
Jan. 24, 2007	Pau, France	Fokker 100	substantial	1 fatal, 54 none
During takeoff for a scheduled flight to Paris, one engine ingested birds and lost power. The airplane overran the 2,500-m (8,203-ft) runway, struck a truck on a road and came to a stop in a corn field. The truck driver was killed.				
Jan. 24, 2007	Butler, Pennsylvania, U.S.	Cessna Citation II	substantial	2 serious, 2 none
During an air-ambulance flight from Winchester, Virginia, the airplane was landed long, overran the 4,800-ft (1,464-m) runway and struck the ILS localizer installation. The two medical crewmembers received minor injuries.				

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.