

Air Tanker Clips Trees

Pilots flew lower than the lead airplane on approach to fire-fighting drop site.

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

Sink Developed in Turn to Final Approach

McDonnell Douglas DC-10-10. Substantial damage. No injuries.

The air tanker crew was fighting a wildfire in the mountains near Tehachapi, California, U.S., on June 25, 2007. “Although the flight crew was experienced with the operation of the accident airplane, they had limited fire-suppression experience,” the U.S. National Transportation Safety Board (NTSB) report said. “[They] obtained the majority of their retardant drop experience — in excess of 100 hours using water for drops — during the certification testing for the airplane [which was modified with a fire-retardant-delivery system].”

The crew was performing their third retardant drop when the accident occurred. Per standard operating procedure, they circled over the drop site and observed the lead airplane fly the intended flight profile for the drop. The pilot of the lead airplane, the type of which was not specified in the report, also briefed the air tanker crew by radio during the maneuver. The procedure called for the air tanker crew to follow the lead airplane during the retardant drop.

“After joining with the lead airplane on the downwind leg for the retardant drop, they descended to about 7,700 ft,” the report said, noting that the air tanker was about 1 mi (2 km) behind the lead airplane. “The run was set for a slight descent down the line of fire on a ridge.”

The report said that the air tanker was lower than the lead airplane when it began the turn toward the drop site. The air tanker crew told investigators that as they performed a 30-degree-banked left turn from the base leg to final approach, the airplane began to sink, and they heard several “thump sounds.”

“The captain verbalized the problem, advanced the throttles and rolled the airplane’s wings level,” the report said. “The flight engineer scanned the [left] wing and noted damage to the aileron, slat and flap.”

The captain performed a climb to 11,000 ft and, with the lead airplane in trail, flew the air tanker to an unpopulated area, where the retardant was jettisoned. The crew then declared an emergency and landed the airplane without further incident in Victorville, California.

“The digital flight data recorder indicated that the airplane had entered a 35-degree left bank with a vertical acceleration from 0.8 to 1.4 g, which is consistent with normal loading in a banked turn,” the report said. Firefighters found that the DC-10’s left wing had struck 13 trees during the turn.



Fuel Leak Causes Nacelle Fire

Boeing 767-300. Substantial damage. No injuries.

The pilots and a line engineer found nothing unusual during their inspections of the 767 before it departed with 135 passengers and 12 crewmembers from Apia, Samoa, for a scheduled flight to Auckland, New Zealand, the morning of Dec. 30, 2006. Shortly after the thrust reversers were stowed on landing at Auckland, the flight crew saw a left-engine fire warning, said the report by the New Zealand Transport Accident Investigation Commission (TAIC).

The crew stopped the aircraft on the runway, reported the fire warning to the airport traffic controller and conducted the “Engine Fire” checklist. They shut down the left engine and activated the fire extinguisher. “All fire indications ceased 27 seconds after the first warning,” the report said. The crew then taxied the 767 onto a taxiway and shut down the right engine.

At the crew’s request, the controller had relayed through ramp personnel a request that aircraft rescue and fire fighting (ARFF) personnel confirm that the fire had been extinguished. The controller told investigators that, because the crew had not declared an emergency, he did not want to activate the crash alarm, which was his only direct means of communication with ARFF.

“Because of miscommunication, uncertainty about the severity of the situation and unfamiliarity with the aerodrome emergency plan, there was a nine-minute delay before the fire service arrived at the aircraft,” the report said.

ARFF personnel confirmed that the fire had been extinguished, and the 767 was towed to the terminal. “Engineers then confirmed that there had been a fire inside the left engine nacelle and that there was a leak from the fuel manifold,” the report said. The leak had been caused by chafing of the fuel manifold by one of the 24 clamps that hold it in a loop around the engine. Cushioning material was missing from inside the clamp, and metal-to-metal wear had created a pinhole in the fuel manifold.

“Chafing was a known service issue that had been addressed by a service bulletin, but the

bulletin instructions were found to be ineffective,” the report said, noting that the damage had not been found during an inspection prescribed by the bulletin 450 flight hours before the fire occurred. After the accident, the engine manufacturer, General Electric, revised the service bulletin to require replacement of all the manifold loop clamps during each inspection.

Wind Shear Blamed for Hard Landing

Cessna 650 Citation III. Substantially damaged. No injuries.

The automatic terminal information service (ATIS) at Atlantic City (New Jersey, U.S.) International Airport was reporting 6 mi (10 km) visibility in light rain and mist, a broken ceiling at 800 ft and winds from 210 degrees at 15 kt, gusting to 24 kt, when the Citation flight crew conducted the global positioning system (GPS) approach to Runway 22 the morning of Oct. 27, 2007. The first officer, who had 2,535 flight hours, including 120 hours in type, was the pilot flying.

The airport traffic controller had issued wind shear advisories to pilots who had previously landed their aircraft on Runway 22 but did not issue an advisory to the Citation crew, the NTSB report said.

The landing reference speed, V_{REF} , was 130 kt, and the captain made several callouts of “ref plus 10” as the airplane broke out of the clouds. The captain told investigators that the first officer appeared to be confused by airspeed indications on his airspeed indicator that were 5 to 10 kt higher than those on the captain’s airspeed indicator. A postaccident examination of the pitot-static system found no anomalies, however.

The first officer saw an indication of 150 kt as the Citation descended below the minimum descent altitude in landing configuration. He reduced power to idle and momentarily deployed the speed brakes. “Review of the airplane flight manual (AFM) revealed that deploying the speed brakes below 500 ft AGL [above ground level], with the flaps in any position other than the retracted position, was prohibited,” the report said.

“There was a nine-minute delay before the fire service arrived at the aircraft.”

The captain told investigators that he believed the airplane developed a high sink rate after encountering a wind shear at about 200 ft AGL. He told the first officer to increase power. “The first officer applied power to the spooled-down engines, but the airplane impacted the runway hard at about the same time the engines were again generating thrust,” the captain said.

The impact drove the right main landing gear into the right wing, and the wing spar was substantially damaged. The Citation bounced, and the crew initiated a go-around. “During the go-around, the captain observed multiple cockpit warnings, including loss of hydraulic pressure, and he planned for a subsequent emergency landing without brakes or thrust reversers,” the report said.

The crew landed the airplane on Runway 31, which, at 10,000 ft (3,048 m), is about 3,850 ft (1,173 m) longer than Runway 22. “During the rollout, the airplane traveled off the end of the runway at a speed of approximately 40 kt and came to rest upright about 100 ft [30 m] beyond the runway,” the report said. None of the four occupants was injured.

Faulty Sensor Triggers Stall Indications

Boeing 747-400. No damage. No injuries.

The 747 was departing from London Heathrow Airport with 386 passengers and 20 crewmembers the afternoon of Dec. 7, 2006, when both stick shakers began to operate continuously at 140 kt — 5 kt below V_1 , the speed at which the flight crew must take the first action to either continue or reject the takeoff following an engine failure at a lower airspeed. “The commander elected to continue the takeoff,” the U.K. Air Accidents Investigation Branch (AAIB) report said.

The copilot continued flying the aircraft and also handled radio communications so that the commander could concentrate on analyzing the situation. “Throughout the initial climb, the commander verified that the aircraft’s speed, attitude and thrust were correct, and he concluded that he had been correct in his initial analysis: the warning was not a genuine indication of

the aircraft approaching an unacceptably high angle-of-attack. ... He pulled both [stick shaker] circuit breakers, which caused the stick shakers to stop [operating].”

The copilot leveled the aircraft at Flight Level (FL) 170 (about 17,000 ft), and the pilots discussed whether they should continue the flight to New York or return to London. During this time, they noticed an “ALT DISAGREE” message on the engine indication and crew alerting system (EICAS) display. Indicated altitudes were FL 170 on the copilot’s primary flight display (PFD), FL 167 on the commander’s PFD and 167 on the standby altimeter. Shortly thereafter, an “IAS DISAGREE” message appeared on the EICAS.

The commander consulted the quick reference handbook but found “no immediate resolution of the condition,” the report said. “The flight crew then determined, from their knowledge of the aircraft’s systems, that the problem was rooted in one of the two air data computers (ADCs).” After switching from the no. 1 ADC to the no. 2 ADC, they found that both PFDs were displaying the same altitudes and airspeeds.

The crew consulted by radio with company operations personnel and decided to return to Heathrow. After dumping some fuel, they landed the 747 without further incident. Maintenance engineers reviewed built-in test equipment (BITE) data for the no. 1 ADC and decided to replace the computer.

After being returned to service, the 747 departed from Heathrow about three hours after the first takeoff. The stick shakers again began to operate 5 kt below V_1 . This time, the crew rejected the takeoff and taxied the aircraft back to the terminal while carefully monitoring brake temperatures. “The passengers were accommodated overnight near the airport, and the flight and cabin crew carried out appropriate post-flight actions before going off duty,” the report said.

Examination of the 747’s pitot-static system the next day revealed that the stick shaker system activated even when the right angle-of-attack (AOA) vane was in a horizontal position. “Accordingly, the right AOA sensor was changed,

“Throughout the initial climb, the commander verified that the aircraft’s speed, attitude and thrust were correct.”

and the system was retested with satisfactory results,” the report said. “The aircraft was returned to service, with no further problems being reported by flight crews.”

Collision During Simultaneous Pushbacks

Boeing 757-200, Bombardier CRJ700. Substantial damage. No injuries.

Night visual meteorological conditions (VMC) prevailed at San Francisco International Airport on Jan. 13, 2008, when the airport ground traffic controller cleared a maintenance technician aboard the 757 for pushback from Gate 80 and, about 41 seconds later, cleared the CRJ flight crew for pushback from Gate 79. “Review of air traffic control (ATC) communication recordings revealed that the ground controller did not advise either aircraft of near-simultaneous pushback operations,” the NTSB report said.

After being pushed back from the gate, the CRJ, with 55 passengers and five crewmembers aboard, was stopped on a taxiway with the engines operating and the parking brake set. The two wing walkers were disconnecting the tow bar when they saw the 757 approaching. They were running toward the 757 to warn the tug operator when the 757’s tail struck the CRJ’s tail.

The 757 had been pushed back without wing walkers or tail walkers. The tug operator told investigators that he did not see the CRJ. He stopped the tug after the maintenance technician on the flight deck felt “several bumps” and asked him if the tow bar had broken or the 757 had “hit something.”

The collision substantially damaged the CRJ’s vertical stabilizer, rudder and elevator, and the 757’s rudder and elevator. There were no injuries.

TURBOPROPS

EMS Flight Strikes Mountain

Raytheon King Air C90A. Destroyed. Three fatalities.

Night instrument meteorological conditions prevailed when the King Air departed from Chinle, Arizona, U.S., with a flight nurse and paramedic for an emergency medical

services (EMS) positioning flight to pick up a patient in Alamosa, Colorado, on Oct. 4, 2007. The pilot did not file a flight plan, and there was no record that he obtained a preflight weather briefing, the NTSB report said.

Shortly after takeoff, the pilot radioed the company’s dispatch office that his planned cruising altitude was 12,500 ft and estimated time en route was 30 minutes. “The company dispatch did not have any flight-following capabilities,” the report said.

The pilot then established radio communication with Denver Center and requested flight-following services. The controller assigned a transponder code and established radar contact with the King Air. Recorded radar data indicate that the airplane climbed to 13,500 ft, descended to 11,500 ft and then climbed back to 13,500 ft.

A few minutes before the crash, the pilot was instructed to change to a different center radio frequency. On initial contact, the pilot reported that he was “on the descent into Alamosa” and requested the minimum vectoring altitude. The controller asked him to repeat the question, and the pilot said, “What is the MSA [minimum safe altitude] out here? Do you know?”

The controller said, “I guess I’m just not understanding what you’re saying. Either I’m really tired [or] you’re talking too fast. Slow her down for me a little, will you?”

The pilot said, “I’m actually new into Alamosa. Just wondering what the minimum descent altitude was out here.” The controller told the pilot that he would be “cutting across the corner” of an area with a minimum instrument altitude of 15,300 ft and that “it goes down after that.” The pilot acknowledged the transmission.

About one minute later, the controller radioed that radar contact had been lost, but there was no reply. The wreckage of the King Air was found the next day at an elevation of 11,900 ft in mountainous terrain about 40 mi (64 km) from Alamosa.

“A review of the handling of the accident flight showed that the controller was aware of the airplane’s position, altitude, general route of flight and its proximity to terrain,” the report said. “No safety alert was issued to the accident flight.”



The report said that the controller's failure to issue a safety alert to the pilot and the pilot's inadequate preflight and in-flight planning and decision making were contributing factors in the accident. The probable cause of the accident was "the pilot's failure to maintain clearance from mountainous terrain," the report said.

Short Touchdown in a Blizzard

British Aerospace Jetstream 31. Substantial damage. No injuries.

The aircraft was on a scheduled flight with 10 passengers from Grande Prairie, Alberta, Canada, to Fort St. John, British Columbia, the morning of Jan. 9, 2007. En route, the flight crew obtained ATIS information indicating that the destination airport had surface winds from 360 degrees at 10 kt, 1 to 3 mi (1,600 to 4,800 m) visibility and a vertical visibility of 2,300 ft.

However, the weather deteriorated rapidly into blizzard conditions as the Jetstream neared Fort St. John, said the report by the Transportation Safety Board of Canada. The crew was conducting the instrument landing system (ILS) approach to Runway 29 when a flight service specialist told them that the wind was from 310 degrees at 30 kt, gusting to 40 kt, runway visual range (RVR) was 2,800 ft (about 880 m) and the sky was obscured. Minimum RVR for the approach was 2,600 ft (about 810 m).

"The first approach was discontinued due to the aircraft being too high on the final approach leg," the report said. During the second approach, the captain, the pilot flying, maintained a flap setting of 20 degrees. The Jetstream was at 300 ft AGL when the first officer called the ground was in sight. He then called the approach lights in sight.

The captain confirmed that the approach lights were in sight and called for the full-flaps setting, 35 degrees. "When the flap setting was increased from 20 degrees to 35 degrees in the final stage of the approach, the aircraft would have become destabilized; there would have been a tendency for the aircraft to pitch up and lose airspeed," the report said. "Since the captain's focus was outside the aircraft and

his attitude reference was reduced in the low visibility, it would have been difficult to judge aircraft pitch attitude and height above the ground."

Neither pilot was monitoring the instruments, and "a significant deviation below the optimum glideslope went unnoticed by the crew," the report said.

The aircraft touched down 320 ft (98 m) short of the runway threshold in about 16 in (41 cm) of packed snow, struck approach lights, bounced and touched down again 180 ft (55 m) short of the threshold. "After sliding through the threshold lights, the aircraft came to rest on the right edge of the runway," the report said. "The main gear had broken off, and the nose gear had collapsed rearward. Both propellers were damaged by ground contact. The aircraft was equipped with a belly-mounted cargo pod, which supported the fuselage during impact."

'Dump' Switch Selected by Mistake

Beech King Air 300. No damage. No injuries.

En route on a charter flight with seven passengers from Melbourne, Victoria, Australia, on Feb. 6, 2007, the King Air was 140 nm (259 km) south of the destination — Alice Springs, Northern Territory — and the pilot was preparing to descend from FL 280 when he felt his ears "pop" and observed indications of rapid depressurization.

After donning his oxygen mask, the pilot ensured that the passengers had donned their oxygen masks, initiated an emergency descent and declared an emergency with ATC, the Australian Transport Safety Bureau report said. He landed the aircraft at Alice Springs without further incident.

The pilot told investigators that during the emergency descent, he noticed that the pressurization system switch, which is on the left side of the center control pedestal, was in the "DUMP" position. "The pilot reported that it is possible that, while adjusting his seat position prior to top of descent, he inadvertently activated the switch to the 'DUMP' position," the report said.

Neither pilot was monitoring the instruments.



PISTON AIRPLANES

Engine Fails During Low, Slow Flight

Piper Aztec. Destroyed. Two fatalities.

Modified with a chemical-dispensing system, the Aztec was on a public-use flight the afternoon of Sept. 14, 2006, spraying insecticide to control mosquitoes near Fort Meade, Florida, U.S. A witness saw the airplane pass overhead at low altitude and heard one of the engines “throttle back, then rev up and sputter,” the NTSB report said.

The witness said that the propeller on the right engine was turning slowly when the airplane pitched nose-up, rolled right and descended to the ground. The pilot and observer were killed.

A teardown inspection of the engines revealed no anomalies, and investigators were unable to determine the cause of the apparent failure of the right engine. The report said that the power loss likely occurred at an airspeed below minimum single-engine control speed (VMC) and “at an altitude too low to afford a safe recovery.”

Misfire Occurs During Overwater Flight

Gippsland Aeronautics GA8 Airvan. Substantial damage. No injuries.

The single-engine utility aircraft was being used for a scheduled flight with one passenger from Wellington, which is on the southern coast of New Zealand’s North Island, to Kaikoura, on the northeast coast of South Island, the morning of Nov. 27, 2006. VMC prevailed, and the pilot planned to conduct the 56-km (30-nm) overwater segment across Cook Strait at 3,000 ft, the TAIC report said.

The pilot told investigators that about eight minutes after takeoff, the engine “gave a kick” and he observed that oil pressure had dropped from the normal 60 psi and was fluctuating around 40 psi. “The pilot reduced power slightly and turned back toward Wellington airport,” the report said. “He advised ATC of the situation and requested priority for landing, but he did not declare any urgency or request the airport rescue services to be placed on standby.”

After the pilot landed the aircraft at Wellington without further incident, metal debris was found in the Lycoming IO-540K engine’s oil sump. A subsequent teardown examination of the engine revealed that the valve tappets in five of the six cylinders had “disintegrated,” the report said. The damage apparently began with the sticking and failure of the exhaust valve tappet in the no. 4 cylinder, but investigators were unable to determine why that tappet failed.

Noting that the aircraft had life vests aboard but did not have, and was not required to have, a life raft, the report said, “The ditching risk that was present with overwater air transport operations with single-engine aircraft and the means of mitigating that risk had not been fully considered by the operator or the [New Zealand Civil Aviation Authority].”

ILS Approach Procedure Not Followed

Cessna 414A. Destroyed. Three fatalities.

As the 414 neared the destination — Lawrenceville, Georgia, U.S. — the night of Dec. 25, 2006, ATC told the pilot that weather conditions at the airport included 1/2 mi (800 m) visibility in fog and a 100-ft ceiling. “The pilot acknowledged the information and elected to continue for the ILS approach,” the NTSB report said.

When the pilot subsequently reported a missed approach, he told ATC that he saw the airport below and intended to conduct another ILS approach. “During the second approach, the tower controller advised the pilot that he was left of the runway centerline,” the report said. “Shortly after the pilot acknowledged that he was left of the centerline, the tower controller saw a bright ‘orange glow’ off the left side of the approach end of the runway.” The 414 had struck trees and crashed in a construction yard.

The report said that the probable cause of the accident was “the pilot’s failure to follow the instrument approach procedure.” A contributing factor was his “descent below the prescribed decision height.”



HELICOPTERS

Lightning Strikes Main Rotor Blades

Eurocopter AS332-L2. Substantial damage. No injuries.

The Super Puma entered a line of rain showers about 15 minutes after taking off from a platform in the North Sea to transport 15 passengers to Aberdeen, Scotland, the afternoon of Feb. 22, 2008. “About 30 seconds after entering the line of showers, both pilots saw a bright flash at the rotor tip in the one o’clock position, accompanied by a ‘bang’ or ‘pop’ sound,” the AAIB report said.

The lightning strike did not cause any noticeable effects, but the pilots decided to divert the flight to the nearest available platform. “It was then established that the nearest suitable platform had unfavorable weather conditions and all other suitable platforms reported winds in excess of 50 kt,” the report said. “The crew therefore elected to continue on to Aberdeen, where an uneventful landing was made.”

Examination of the helicopter revealed that all four main rotor blades had been damaged and that one blade had been damaged beyond repair. “The damage included arcing damage to the leading edge anti-erosion strips, broken bonding leads and damaged trim tabs,” the report said. “High-energy tracking was also visible on two main rotor pitch link ball joints and one main rotor servo upper ball joint.”

No air-to-ground lightning strikes had been recorded near the helicopter. “The physics of lightning is far from perfectly understood, but it would appear that the event ... was probably an inter-cloud or intra-cloud strike,” the report said. “Such an event is frequently triggered by the presence of an aircraft.”

Mast Bumping Causes Main Rotor Separation

Fairchild Hiller FH-1100. Destroyed. Two fatalities.

The commercial pilot had purchased the helicopter in Century, Florida, U.S., and was flying it to his home base in Nevada on Sept. 12, 2007, accompanied by a passenger who held a private pilot certificate for helicopters. “Following a fuel stop [in Mississippi], they had progressed approximately 180 nm [333 km]

when the helicopter’s main rotor and rotor hub assembly separated from the upper mast,” the NTSB report said. “The helicopter subsequently entered an uncontrolled descent and impacted the ground.”

The crash occurred in VMC near Hosston, Louisiana. Shortly before the accident, a witness had seen the helicopter flying at treetop level. She said that the helicopter was “not moving fast” and thought that it was going to land on the front yard of her home.

Examination of the helicopter revealed signs of mast bumping, in which the rotor head strikes the rotor mast. “Though there was evidence of a mast-bumping event, the initiating event is unknown,” the report said. “Examination of the wreckage disclosed no anomalies that would have prevented normal system operation, and the [turboshaft] engine displayed evidence of rotation at the time of ground impact. The cockpit also exhibited damage consistent with main rotor contact.”

Instructor, Student Wrestle for Control

Robinson R44 II. Destroyed. Two minor injuries.

During an instructional flight in Missoula, Montana, U.S., on June 14, 2008, the student pilot was turning left base to land in an open field. “The instructor noted that the helicopter was descending faster than anticipated and that ‘the collective was too far down, the cyclic was too far back, and [the student] had a tight hold on both controls,” the NTSB report said.

The flight instructor attempted to take over but could not break the student’s grip on the controls. “The instructor said that no words were spoken as he struggled with the student for control of the helicopter for a period of three or four seconds,” the report said.

The R44 landed hard, rolled onto its left side and began to burn. The instructor and student were able to evacuate the helicopter before it was engulfed by the fire. The report said that a contributing factor in the accident was the instructor’s “failure to verbally command the student to relinquish the controls.”

Preliminary Reports				
Date	Location	Aircraft Type	Aircraft Damage	Injuries
Sept. 1, 2008	Bukavu, Democratic Republic of Congo	Beech 1900C-1	destroyed	17 fatal
The airplane was on a humanitarian flight when it struck a ridge on approach to Bukavu in adverse weather conditions.				
Sept. 1, 2008	Reno, Nevada, U.S.	Lockheed SP-2H Neptune	destroyed	3 fatal
The air tanker was taking off to drop retardant on a wildfire when the left jet engine and left wing caught fire. The airplane then struck power lines and crashed.				
Sept. 1, 2008	Columbus, Ohio, U.S.	Convair 580	destroyed	3 fatal
The Convair crashed in a cornfield shortly after taking off from Rickenbacker Airport for a post-maintenance test flight.				
Sept. 3, 2008	São Paulo, Brazil	Beech King Air C90B	destroyed	3 none
The King Air overran the runway on takeoff from Congonhas Airport and struck a wall.				
Sept. 3, 2008	Persian Gulf	Bell 212	substantial	7 fatal
Night visual meteorological conditions prevailed when the helicopter struck a crane while taking off from an offshore platform.				
Sept. 7, 2008	Belize City, Belize	Cessna 208B Caravan	destroyed	5 NA
The Caravan crashed in 2.0 ft (0.6 m) of water when the pilot attempted to land on a beach after the engine failed. All five occupants sustained unspecified injuries.				
Sept. 13, 2008	Bakalan, Malaysia	DHC-6 Twin Otter	substantial	14 NA
No fatalities were reported when the Twin Otter crashed into a house short of the runway while landing.				
Sept. 14, 2008	Kununurra, Western Australia	Robinson R44	destroyed	4 fatal
The helicopter crashed during an air tour flight in a national park.				
Sept. 14, 2008	Perm, Russia	Boeing 737-500	destroyed	88 fatal
En route from Moscow, the 737 either was descending to land or on a missed approach when it crashed in adverse weather conditions at 0510 local time.				
Sept. 15, 2008	Ojinaga, Mexico	Cessna 421B	destroyed	4 fatal
The airplane crashed about 100 ft below the top of a ridge during a visual flight rules flight from El Paso to Presidio, both in Texas, U.S. The Cessna had been chartered to allow Mexican and U.S. authorities to assess flood conditions.				
Sept. 19, 2008	Columbia, South Carolina, U.S.	Learjet 60	destroyed	4 fatal, 2 serious
The Learjet overran the 8,000-ft (2,438-m) runway on takeoff and struck an embankment. The pilots reportedly had attempted to reject the takeoff after a tire burst.				
Sept. 21, 2008	Villarsel-le-Gibloux, Switzerland	Pacific Aerospace 750XL	destroyed	2 fatal
The single-turboprop utility airplane crashed in a wooded area while returning to Ecuwillens after releasing 17 skydivers.				
Sept. 22, 2008	Quito, Ecuador	Fokker F28	destroyed	66 NA
The flight crew rejected the takeoff due to a fire warning. The Fokker overran the 10,240-ft (3,121-m) runway and struck a brick wall. Eight passengers were injured; the extent of their injuries was not specified.				
Sept. 25, 2008	Talbot Bay, Western Australia	Bell 407	destroyed	7 NA
The helicopter struck the water shortly after taking off from a holiday vessel. The seven occupants exited the 407 before it sank.				
Sept. 25, 2008	Bridgewater, Virginia, U.S.	Beech King Air A200	substantial	2 none
The King Air landed long, overran the 2,745-ft (837-m) runway and came to a stop in a creek.				
Sept. 26, 2008	Vineyard Haven, Massachusetts, U.S.	Cessna 402C	destroyed	1 fatal
The 402 crashed shortly after departing for a scheduled flight.				
Sept. 27, 2008	Kirke Såby, Denmark	Robinson R22	destroyed	2 NA
The helicopter crashed on a playing field during an aerial photography flight.				
Sept. 28, 2008	Capitol Heights, Maryland, U.S.	Aerospatiale Dauphin	destroyed	4 fatal, 1 serious
The crew of the emergency medical services helicopter encountered adverse weather conditions after picking up two victims of an automobile accident. The pilots diverted the flight to Andrews Air Force Base. One patient survived when the Dauphin crashed in a wooded area on approach.				
Sept. 29, 2008	Santa Fe, New Mexico, U.S.	Pilatus PC-12/47E	destroyed	1 fatal
The airplane was being delivered to Santa Fe from New York, with a fuel stop in Texas, when it crashed 4 nm (7 km) from the airport at 0440 local time.				
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.				