Taxiway Touchdown

A nighttime circle-to-land maneuver misses the target.

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

Glide Path Lights in Unusual Location

Boeing 757-200. No damage. No injuries.

Weather conditions at Newark (New Jersey, U.S.) Liberty International Airport the night of Oct. 28, 2006, included surface winds from 280 degrees at 25 kt, gusting to 34 kt, 10 mi (16 km) visibility and a broken ceiling at 7,000 ft when the flight crew was cleared to conduct the instrument landing system (ILS) approach to Runway 22L. The 757, inbound from Orlando, Florida, with 148 passengers and six crewmembers, was descending through about 9,000 ft when air traffic control (ATC) told the crew to circle to land on Runway 29, said the report by the U.S. National Transportation Safety Board (NTSB).

The captain had about 24,000 flight hours, including 34 flight hours in 757s. The first officer, the pilot flying, had about 6,200 flight hours, including 388 flight hours in type. "The incident flight was the first officer's first approach to Runway 29," the report said.

The first officer disengaged the autopilot when the airplane intercepted the glideslope for Runway 22L, hand flew the 757 to the outer marker, which is 4.4 nm (8.1 km) from the runway threshold, and disengaged the flight director. At 900 ft, the minimum circling altitude, he maneuvered the airplane to line up with Runway 29, which is 6,800 ft (2,073 m) long and 150 ft (46 m) wide. Runway 29 and Runway 22L intersect near their approach thresholds.

"As he rolled the airplane level, he noted four white lights on the PAPI [precision approach path indicator] and pitched the airplane nose-down to capture the proper glide path," the report said. Both pilots believed that the PAPI was on the left side of the runway, the usual location. However, the PAPI for Runway 29 is on the right side of the runway.

"The flight crew believed that they had the runway centerline lights in view," the report said. "As the airplane descended below 300 ft, it flew through an intermittent rain shower, briefly reducing the flight crew's view of the runway. After clearing the rain shower, the flight crew confirmed final glide path alignment and noted that the PAPI appeared extremely bright compared to other lights."

The 757 touched down at about 140 kt. "As the first officer deployed the thrust reversers,

the captain realized that they had landed on Taxiway Zulu and took control of the airplane," the report said. Taxiway Zulu is 75 ft (23 m) wide and is parallel to, and to the right of, Runway 29. The captain taxied the airplane to the gate without further incident.

The runway end identifier lights, the green high-intensity lights marking the edges of the approach end and the white centerline lights on Runway 29, as well as the green centerline lights on Taxiway Zulu, were illuminated. The taxiway also has blue reflective markers at its edges. "According to airport personnel, six aircraft made the same approach within 10 minutes of the incident aircraft and landed successfully on Runway 29," the report said.

The report noted that after the incident, the U.S. Federal Aviation Administration (FAA) approved Runway 29 area navigation transition procedures for the operator.

Landing Gear Damage Not Detected

Airbus A320-200. Substantial damage. No injuries.

The A320 was 5 nm (9 km) from Runway 09 at Bristol (England) Airport the night of Nov. 15, 2006, when the airport traffic controller cleared the flight crew to land and advised that surface winds were from 180 degrees at 23 kt, gusting to 33 kt. "There was no significant turbulence until the aircraft descended below 250 ft AGL [above ground level]," said the report by the U.K. Air Accidents Investigation Branch (AAIB).

When the commander disengaged the autopilot at 100 ft AGL, the aircraft suddenly rolled left.

When the commander disengaged the autopilot at 100 ft AGL, the aircraft suddenly rolled left. The commander rolled the wings level and continued the approach. "At about 70 ft AGL, there was another uncommanded roll to the left, but this was again corrected promptly by the commander," the report said. After he retarded the throttles and began the flare, the A320 sank. It touched down with a 30-kt crosswind and 10-kt tailwind; pitch attitude was 5.5 degrees nose-up. The first officer recalled that the right main landing gear touched down first, and she believed that the aircraft was going to become airborne again.

"The aircraft bounced slightly, and the commander was aware of the [first officer] calling 'go around,'" the report said. "However, he had already selected reverse thrust on both engines, and, with the spoilers deployed, he responded 'no.'" The crew brought the aircraft to a stop on the runway and then taxied to the stand.

The aircraft integrated data system generated a "LOAD <15>" report, which indicated a hard landing. The commander entered the report in the A320's technical log and gave the paper copy of the report to an engineer. "The commander also reported that they had landed quite hard and [asked] the engineer [to] have a look around the aircraft; his main concern was that there may have been evidence of a tail scrape," the report said.

The engineer had not seen a "LOAD <15>" report before. He consulted the aircraft maintenance manual and decided that a hard/overweight landing check was required. This check calls for the airplane to be placed on jacks if external damage is found. The engineer decided that placing the A320 on jacks was not necessary. "The check did not reveal any visible signs of damage, and the engineer released the aircraft back into service," the report said.

The next day, a different flight crew was unable to retract the landing gear on takeoff. The electronic centralized aircraft monitor (ECAM) displayed multiple warnings, including a partial failure of the anti-ice system and an inoperative no. 1 engine thrust reverser. After the crew cycled the landing gear, "the gear retracted correctly, but the other warnings remained, together with others that cycled on and off," the report said.

The crew declared an urgency and flew the aircraft in a holding pattern. "The crew decided to divert to Manchester, an airfield with a long runway, where the weather conditions were good and, because it was their main operating base, where appropriate maintenance support was available," the report said.

The crew lowered the landing gear before leaving the holding pattern. "The crew subsequently completed the 'Overweight Landing

Check' before making a gentle touchdown on Runway 24L at Manchester," the report said.

The automatic post-flight report indicated a problem with a gear-position sensor. The sensor was replaced, and an engineer released the aircraft to service. The flight crew that landed the A320 at Manchester then departed in the aircraft for a ferry flight back to Bristol. "After takeoff, the landing gear failed to retract, and the crew were presented with almost the same warnings as on the previous flight," the report said. "They reselected the landing gear down, declared a 'PAN' and returned to land at Manchester."

The aircraft was taken to a hangar and placed on jacks. "During the jacking, it became evident that the right main landing gear had suffered severe internal damage," the report said. "The internal upper diaphragm tube had ruptured, allowing the inner sliding tube to overextend. … The attached axle and the main wheels were only prevented from detaching by the torsion links."

Elevator Separates During In-Flight Upset

Learjet 36. Substantial damage. No injuries.

Two Learjets rendezvoused over the Pacific Ocean, about 100 nm (185 km) west of North Island Naval Air Station in San Diego, the morning of Dec. 1, 2006, to participate in tests of a U.S. military command and control system. Visual meteorological conditions (VMC) prevailed in the area, but the horizon reportedly was difficult to discern.

The accident airplane was flown 1,000 ft below and slightly behind the other Learjet for the first test. "The run was uneventful except for increasing communications difficulties with the test controllers," the NTSB report said.

While attempting to re-establish communication with the controllers, the flight crew of the lead airplane began a left orbit at about 25,000 ft. While maneuvering the accident airplane to an in-trail position at the same altitude, the pilot lost sight of the other Learjet and rolled right. "Unable to see the horizon or the other airplane, he attempted to transition to instrument references," the report said. "But his vision was still impaired by the glare from the sun, delaying his recognition of the airplane's attitude."

The Learjet was in a 70-degree right bank and a 50-degree nose-down attitude when the pilot began to recover. "The pilot moved the thrust levers rapidly to idle, rolled to a wings-level attitude and began the dive recovery," the report said. "He noted that the airspeed seemed to stabilize at 380 KIAS [knots indicated airspeed]. Both crewmembers felt that the pull-up was completed smoothly, without excessive g force."

The Learjet was in a 70-degree right bank and a 50-degree nose-down attitude when the pilot began to recover.

The pilots said that the airplane shuddered during the dive recovery, but they "did not recall any rolling tendencies or vibration of the control yokes … or any unusual noises other than the loud wind noise," the report said. However, the equipment operator, who was seated in the cabin, heard a very loud bang before the shuddering ceased.

The dive recovery was completed at 16,000 ft. The pilots noticed no unusual handling qualities as airspeed decreased to 200 KIAS. "The crew conducted a controllability check by slowing it to 150 KIAS and lowering the landing gear," the report said. "Again, the airplane exhibited no unusual flight characteristics."

The crew flew the airplane back to base and landed without further incident. A post-flight inspection revealed that the right elevator was missing. The report concluded that the Learjet's design stress limits likely had been exceeded during the upset and recovery.

Hot, Flat Approach Results in Overrun

Cessna Citation 560. Substantial damage. No injuries.

The pilot told NTSB investigators that surface wind direction was variable and velocity was 3 to 5 kt when he conducted a visual approach to the 4,200-ft (1,280-m) runway in Hamilton, Montana, U.S., the morning of July 10, 2006. During final approach, the pilot observed airspeed fluctuations of plus/minus 10 kt and increased his target approach speed from 98 to 108 kt.

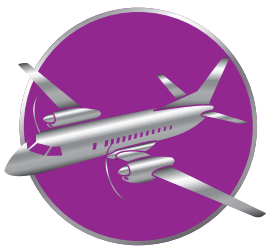
The pilot said that just after he flared and reduced power to idle, the Citation encountered a gust of wind that caused it to float and

touch down between 1,000 and 1,300 ft (305 and 396 m) beyond the runway threshold. He was not able to move the thrust-reverse levers beyond the "DEPLOY" position to increase reverse thrust. He then applied maximum wheel braking but did not notice any significant deceleration.

The copilot told investigators that the pilot had conducted a long, flat approach and crossed the runway threshold 10 kt too fast. The copilot said that the Citation touched down about 2,200 ft (671 m) beyond the threshold and that he did not feel any braking occur until the airplane was about 500 ft (152 m) from the departure end of the runway.

The Citation overran the runway onto rough, swampy terrain. The nosegear collapsed, and the wings and right main landing gear were damaged substantially.

At the airplane's landing weight and with an approach speed of 108 kt, calculated landing distance was 3,100 ft (945 m); the calculation does not include the landing performance provided by reverse thrust. A Cessna representative told investigators that when the Citation's thrust-reverse levers are moved to the "DEPLOY" position, the reversers deploy fully in about two seconds and a solenoid releases the levers so that reverse thrust can be increased. "If a pilot applies pressure to the reverser levers prior to the time the solenoid releases them — and that pressure is maintained during and after the time the solenoid is activated — the reverser lock-out pin may not be able to release, and the levers will not be able to be moved past the 'DEPLOY' position," the report said.



TURBOPROPS

Propeller Feathers During Go-Around

Convair 580A. Substantial damage. One fatality, two serious injuries.

The flight crew of the fire-fighting aerial tanker was conducting stop-and-go landings at the airport in La Ronge, Saskatchewan, Canada, during a training flight on May 14, 2006. "The first two circuits were unremarkable; all altitudes, speeds and aircraft performance were as expected for the exercises being carried out," said the report by the Transportation Safety Board of Canada (TSB).

The third approach was not stabilized. The contract training captain, who had 750 flight hours in type and was the pilot flying, used an airspeed of 103 KIAS instead of the recommended 120 KIAS, a power setting that was less than half the normal setting, and a flap setting of 28 degrees rather than the 24 degrees selected for the first two approaches.

Sink rate increased to about 1,280 fpm on short final approach, and the aircraft descended almost to ground level. The captain called for increased power. The first officer rapidly advanced both power levers, and power increased beyond the maximum limit, triggering the autofeather system. The captain retarded the power levers to a position that he believed would produce maximum power, but the autofeather system already had begun to feather the left propeller and shut down the left engine. "The autofeather was not called out or identified as an emergency," the report said.

The Convair bounced when it touched down about 200 ft (61 m) beyond the runway threshold, with 4,750 ft (1,448 m) of runway remaining — which was more than sufficient to complete the landing, the report said. However, the captain rejected the landing. Airspeed was about 94 KIAS — 2 kt lower than V_1 — when the go-around was initiated. Soon after the aircraft became airborne, it entered a slight left bank that the captain was unable to correct. The landing gear was retracted during a momentary indication of a positive rate of climb and the flaps were retracted at 95 KIAS. "Once the flaps were retracted … the angle of bank increased uncontrollably," the report said. "The aircraft started to descend and collided with trees and terrain in a wooded area on the airport property." The first officer was killed; the captain and a pilot occupying the observer's seat were seriously injured.

The autofeather system in the Convair activates when it senses that a high power setting has been selected — that is, one or both

power levers are beyond a specific position — but propeller thrust is less than 500 lb. "This 'committed' type of autofeather system does not incorporate a timed delay; such a device would allow for transient propeller thrust during engine 'spool-up,'" the report said. "Testing of a similarly equipped aircraft revealed that it is possible to induce an unwarranted activation of the aircraft's autofeather system by rapidly advancing the power levers when the propellers are in a low-thrust condition."

Caught Between Layers

Cessna 208. No damage. No injuries.

Soon after departing with 10 passengers from Broome, Western Australia, for a visual flight rules (VFR) charter flight to Talbot Bay, the morning of June 20, 2007, the pilot found that he would not be able to climb to his planned cruise altitude of 5,500 ft because of clouds. "The pilot therefore decided to level the aircraft at about 2,500 ft and continue toward Talbot Bay," said the Australian Transport Safety Bureau report. About 10 minutes later, another cloud layer began to build below the float-equipped Caravan.

"Approximately 35 to 40 minutes into the flight, the weather conditions deteriorated further," the report said. "The pilot reported showers and 'a wall of cloud' ahead, around which he was unable to divert." The pilot, who did not hold an instrument rating or a night VFR rating, decided to return to Broome.

The aircraft was between cloud layers and 83 km (45 nm) from Broome when it encountered rain showers that significantly reduced visibility. The pilot began a left turn toward an area he recalled as having better visibility. "The pilot reported that, following the turn, he began to feel disoriented and had difficulty controlling the aircraft's roll attitude," the report said.

The pilot radioed on the common traffic advisory frequency of a local airport that he needed assistance. The flight crew of an aircraft 130 km (70 nm) northeast discontinued an approach to assist the pilot. They coached the pilot on using his flight instruments to maintain control. "The crew of the assisting aircraft reported that, about five minutes after the initial radio contact, 'the pilot of the [Caravan] sounded less stressed and advised us he was in level flight,'" the report said. "The pilot of the Caravan subsequently advised that he was continuing to Broome [and] required no further assistance."

The report said that the pilot assumed an "elevated risk of collision with terrain" when he conducted a descent through the lower cloud deck without knowing the lowest safe altitude in the area or the minimum sector altitude. "The pilot indicated that he was using a global positioning system (GPS) moving map display to provide an indication of the surrounding terrain," the report said. After descending clear of the clouds at an undetermined altitude, the pilot landed without further incident.

The pilot assumed an "elevated risk of collision with terrain" when he conducted a descent through the lower cloud deck.

Grease Contamination Leads to Gear Failure

Beech B200. Substantial damage. No injuries.

When the flight crew attempted to retract the landing gear during departure from Caen, France, on March 24, 2007, they heard an unusual noise and saw that the "GEAR UNSAFE" light remained illuminated. A reflection of the nosegear in the engine cowlings showed that the nosegear "appeared to be extended, but at a slight angle from its normal down position," the AAIB report said. "The crew selected the landing gear down and obtained two green lights for the main gear but no such indication for the nosegear. They then selected it up again, but the nosegear remained in its previous position."

The crew continued toward the destination, Stapleford Aerodrome in Essex, England, but decided to divert to Southend Airport in Essex, where the operator's maintenance organization was based. The "GEAR UNSAFE" light remained illuminated when they extended the landing gear. "They then attempted to lower the nosegear using the manual extension system, but without success," the report said.

Airport emergency services were standing by when the Super King Air touched down on

its main landing gear. As briefed, the copilot feathered the propellers and shut down the engines while the commander held the nosegear off the runway as long as possible. The nosegear collapsed when it touched down at an estimated groundspeed of 65 kt. The pilots and the five passengers were not injured.

Examination of the nosegear showed that all the threads in the nut on the screw-driven actuator had been stripped. The wear had occurred over time due to water contamination of the grease inside the actuator. The contamination had reduced the lubricating properties of the grease and corroded the screw. "The corrosion pits formed were likely to have increased the roughness of the screw and accelerated wear of the nut," the report said. Based on the incident investigation, the AAIB recommended that the FAA require periodic lubrication and more frequent inspections of the nosegear actuators in B200s.

PISTON AIRPLANES

Power Loss Leads to Ditching

Douglas DC-3. Destroyed. One minor injury.

The crew had delivered mail to St. Thomas, U.S. Virgin Islands, and were returning to San Juan, Puerto Rico, the morning of July 19, 2006, with no cargo aboard the DC-3. The airplane was at about 100 ft AGL on takeoff, and the first officer, the pilot flying, had just called for the landing gear to be retracted when the left engine lost power.

The captain took control, verified that the left engine had failed and feathered the propeller. "The airplane would not maintain altitude, and the airspeed dropped to about 75 kt," the NTSB report said. The captain told the two passengers to don their life vests and then ditched the airplane in the Caribbean Sea about 1 mi (2 km) from the runway. One passenger received minor injuries.

"All aboard managed to exit the airplane through the cockpit overhead escape hatch onto the life raft as the airplane remained afloat," the report said. "About 10 minutes later, the airplane sank nose-first straight down [and] came to rest at the bottom of the ocean, in about 100 ft of water." The DC-3 was not recovered.

Decision to Reject Landing Made Too Late

Piper Chieftain. Destroyed. One fatality, one serious injury.

The flight crew was conducting a 30-minute positioning flight on March 8, 2006, from Vancouver, British Columbia, Canada, to pick up cargo at the Powell River airport, which is uncontrolled and has no advisory service. On arrival, the crew established the airplane on a right downwind for landing on Runway 09, which is 1,106 m (3,629 ft) long.

The TSB report said that a cold front was passing through the area, and, during the Chieftain's approach, the surface winds changed from 120 degrees at 6 kt to 200 degrees at 10 kt, gusting to 37 kt. Visibility decreased from 10 mi (16 km) to 4 mi (6 km) in rain showers and ice pellets.

The aircraft was low and fast on final approach. The crew conducted a go-around and prepared for another visual approach. "It is evident that any cues received on the first approach were not sufficiently compelling to the crew to cause them to abandon their stop at Powell River or to change runways," the report said. "The downwind condition on [final] approach contributed to the aircraft landing long and with a high groundspeed."

The Chieftain touched down with about 550 m (1,805 ft) of runway remaining and began to hydroplane on the wet runway. "At some point after the touchdown, engine power was added in an unsuccessful attempt to abort the landing," the report said. "The aircraft overran the end of the runway and crashed into an unprepared area within the airport property." The copilot was killed, and the pilot was seriously injured.

Broken Manifold Causes In-Flight Fire

Piper Cherokee 6. Destroyed. No injuries.

During a scheduled flight from Juneau, Alaska, U.S., to Kake on June 11, 2007, the passengers complained about an odor in the cabin. The pilot suspected an exhaust

leak but found nothing abnormal when he examined the engine after landing. During the subsequent takeoff with two new passengers aboard, the pilot heard a loud bang and saw flames near his feet. The passengers saw smoke appear near the rear of the cabin and become so dense that they no longer could see the pilot, the NTSB report said.

The pilot retarded the throttle and landed the airplane on the runway. He then helped the passengers evacuate. The pilot told investigators that in his haste to get out of the airplane, he had not turned off the electric fuel-boost pump, which continued to pump fuel through a melted fuel line. The fuel pooled on the ground and was ignited, destroying the Cherokee.

Examination of the engine revealed that fatigue fractures had caused a large piece of the right exhaust manifold to separate. "Hot exhaust gases burned a hole in the heater shroud at the point where it attaches to the scat tubing which provides heated air to the vents in the rear of the passenger cabin," the report said. "The hot exhaust gases also were deflected by the firewall onto the fuel line attached to the engine-driven fuel pump. … According to airplane records, the exhaust system had been inspected in accordance with the operator's approved inspection program 2.9 flight hours prior to the accident."

HELICOPTERS

Controls Bind During Sling Operation

Eurocopter AS 350B2. Substantial damage. No injuries.

After completing sling-load operations at a mining site in Kamarang, Guyana, on Feb. 6, 2005, the pilot began coiling the 120-ft (37-m) longline on the ground below the Canadian-registered helicopter. After descending to about 10 ft AGL, the pilot felt a control restriction in the anti-torque pedals. "The pilot also recognized that he now had considerable physical difficulty controlling the cyclic and collective sticks, and was close to losing attitude control of the helicopter as it gyrated in the pitch, roll and yaw axes," the TSB report said.

At about 20 ft AGL, the pilot retarded the throttle, and the helicopter descended rapidly. "Immediately before impact, the pilot applied considerable force to raise the collective lever, which likely reduced the rate of descent," the report said, noting that the pilot is a "tall and powerful man." The helicopter bounced and came to rest on its skids. The hard landing fractured the left skid tube and a flexible arm on the main rotor head.

Examination of the helicopter revealed several anomalies, including contamination of the hydraulic fluid and the circuit boards that control the hydraulic system. However, the cause of the flight control malfunction was not determined. The report cited several recent AS 350 accidents and incidents involving flight control problems caused by hydraulic system malfunctions. "The AS 350B2 can be controlled without hydraulic servo actuators, but it requires the pilot to exert considerable muscular effort," the report said. "The best course of action is for pilots to be well-trained and prepared for hydraulics-out flight, and for the hydraulic servos to be maintained within fine tolerances."

'Overpitching' Cited in Tail Rotor Strike

Robinson R22 Beta. Substantial damage. No injuries.

The pilot was air-taxiing the helicopter backward while preparing to depart from a field near his home in Ballyragget, Ireland, for a business flight on April 10, 2007. He told investigators that his "overpitching of the flight controls" caused a "seesaw motion" of the helicopter that resulted in a tail rotor strike, said the report by the Irish Air Accident Investigation Unit.

The pilot lowered the collective, and the helicopter landed hard but remained upright on its skids. "Post-accident inspection showed that the tail rotor blades had disintegrated, damage was caused to the tail rotor gearbox as a result of severance of the tail boom, the right skid was damaged and rivets popped on the main gearbox fairing assembly," the report said.

Preliminary Reports

Date	Location	Aircraft Type	Aircraft Damage	Injuries
May 2, 2008	Rumbek, Sudan	Beech 1900C	destroyed	21 fatal
The airplane crashed about 45 km (24 nm) from Rumbek after both engines lost power during a charter flight from Wau.				
May 9, 2008	Muanda, Democratic Republic of Congo	Bell 206L-1	destroyed	1 fatal
The LongRanger crashed and sank in the Atlantic Ocean during a positioning flight between tanker ships.				
May 9, 2008	Ada, Michigan, U.S.	Cessna 208B	destroyed	1 none
The Caravan struck trees after losing power on approach to Traverse City during a cargo flight.				
May 10, 2008	La Crosse, Wisconsin, U.S.	Eurocopter EC 135	destroyed	3 fatal
The emergency medical services helicopter struck the top of a ridge during a nighttime positioning flight.				
May 13, 2008	Cranbrook, British Columbia, Canada	Bell 206B	destroyed	4 fatal
The JetRanger was on a pipeline-inspection flight when it developed engine problems and crashed in a residential area, killing one person on the ground.				
May 15, 2008	Esperanza, Peru	Cessna 210M	destroyed	5 fatal, 1 NA
The airplane crashed in a forest about 50 km (27 nm) west of Esperanza during a passenger flight to Pucallpa.				
May 16, 2008	Pohnpei, Federated States of Micronesia	Boeing 727-200	minor	5 none
The cargo airplane overran the runway while landing and came to a stop in shallow water.				
May 17, 2008	Mumbai, India	Boeing 777-200	substantial	4 none
Four engineers preparing the parked 777 for a flight escaped injury when the nosewheel collapsed.				
May 17, 2008	Stehekin, Washington, U.S.	de Havilland DHC-2	substantial	2 fatal, 3 minor
The wheels on the amphibious landing gear were extended when the Beaver was landed on Lake Chelan. The airplane flipped over and came to rest inverted. Two passengers were killed.				
May 23, 2008	Billings, Montana, U.S.	Beech 1900C	destroyed	1 fatal
The airplane crashed into a warehouse soon after taking off for a nighttime cargo flight.				
May 24, 2008	Avalon, California, U.S.	Aerospatiale AS 350D	destroyed	3 fatal, 3 serious
The helicopter was at about 300 ft on approach to Catalina Island when witnesses heard a pop and saw flames emerge from the engine. The pilot and two passengers were killed when the aircraft struck the ground.				
May 25, 2008	Brussels, Belgium	Boeing 747-200	destroyed	5 none
The flight crew reportedly rejected the takeoff after hearing loud bangs. The cargo airplane then overran the 9,800-ft (2,987-m) runway.				
May 26, 2008	Goma, Democratic Republic of Congo	Antonov An-32	destroyed	5 NA
The An-32 was departing for a cargo flight when the crew reported engine problems and turned back to the airport. Two occupants reportedly were injured when the airplane overran the runway on landing.				
May 26, 2008	Chelyabinsk, Russia	Antonov An-12	destroyed	9 fatal
Soon after taking off for a positioning flight, the crew reported smoke in the cockpit and were attempting to return when the cargo airplane crashed in a field about 15 km (8 nm) from the airport.				
May 29, 2008	Panama City, Panama	Bell UH-1N	destroyed	11 fatal, 1 NA
Two of the three crewmembers and all the passengers, who were Chilean and Panamanian police officials en route to an anti-terrorism conference, were killed when the helicopter crashed into an office building,				
May 30, 2008	Tegucigalpa, Honduras	Airbus A320	destroyed	5 fatal, 118 NA
A tropical storm was producing high winds and heavy rain when the A320 overran the 6,112-ft (1,863-m) runway on landing and struck several motor vehicles before coming to a stop against an embankment. The captain, two passengers and two motorists were killed. At least 81 passengers reportedly were injured.				
May 30, 2008	Lillo, Spain	Pilatus PC-6	destroyed	2 fatal, 9 NA
A wing reportedly separated from the airplane during a skydiving-training flight. Nine skydivers jumped from the PC-6 before it struck terrain.				

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.