

NTSB Findings

1. The accident occurred when the airplane's engines lost power as a result of fuel exhaustion while the flight was maneuvering for a second instrument approach to JFK airport.
2. Examination of the airplane revealed no malfunction of the engines or fuel system components that could have caused a premature fuel exhaustion.
3. The flightcrew was not provided with, and they did not request before departure, the most current weather forecast available for the destination and selected alternate airport.
4. The alternate airport selected for the flight at the time of departure did not meet the prescribed weather criteria for an alternate based on weather information provided to the crew at the time of departure. The weather conditions worsened at both the destination and alternate while the flight was en route.
5. The flight plan of AVA052 did not reflect the most current upper air data or the actual gross weight of the airplane upon departure from Medellin.
6. The flightcrew had received appropriate flight and ground training for the flight, and they possessed appropriate flight and medical certification required by the Government of Columbia.
7. The flightcrew was experienced in conducting B-707 flights from Columbia to the United States.
8. There was no flight following or interaction with the Avianca Airlines dispatcher for AVA052 following takeoff from Medellin. None was required by the airline's operations specifications issued by the FAA under 14 CFR 129 to operate into the United States.
9. There is no record that while en route the flightcrew requested updated weather information from any source regarding the destination or alternate airport.
10. The flightcrew did not adequately communicate its increasingly critical fuel situation to the controllers who handled the flight.
11. The first officer, who made all recorded transmissions to U.S. controllers, was sufficiently proficient in English to be understood by personnel.
12. The first officer incorrectly assumed that his request for priority handling by air traffic control had been understood as a request for emergency handling. The captain experienced difficulties in monitoring communications between the flight and air traffic control.
13. The controller's actions in response to AVA052's requests were proper and responsive to a request for priority handling. They did not understand that an emergency situation existed.
14. The first officer, who made all recorded radio transmissions in English, never used the word "Emergency," even when he radioed that two engines had flamed out, and he did not use the appropriate phraseology published in United States aeronautical publications to communicate to air traffic control the flight's minimum fuel status.
15. The weather conditions at the JFK Airport were worse than forecast.
16. The captain did not fly the ILS approach in a stabilized manner, which led to a serious deviation below the glideslope and to his initiation of a go-around.
17. A windshear on the approach path contributed to the captain's poor performance on the ILS approach. Although other flights successfully completed the approach through the same wind conditions, the captain's performance on the approach was probably degraded by fatigue after a long flight and by his reliance on raw glideslope position data rather than on autopilot or flight director guidance.
18. The FAA traffic management programs failed to manage the traffic volume at JFK effectively, leading to excessive delays and airborne holdings, including more than 1 hour for AV052.
19. The FAA's traffic management programs for JFK did not adequately account for overseas arrivals and missed approaches to JFK.
20. Cabin crewmembers and passengers were not warned of the impending crash landing, which may have contributed to the severity of the injuries sustained.

21. The serious and fatal injuries were the result of blunt force trauma because of high vertical and longitudinal deceleration forces during the impact sequence.
22. The emergency evacuation slides were inoperative because of the lack of slide girt bars and associated attachment hardware.
23. There were no shoulder harnesses or inertia reels installed on captain's and first officer's seats.
24. The response of fire and rescue personnel was timely and effective, and the use of helicopters by the Nassau County Police Department probably saved lives.