



Section/division Accident and Incident Investigations Division Form Number: CA 12-57

LIMITED SERIOUS INCIDENT INVESTIGATION REPORT

Reference Number		CA18/3/2/1353																
Classification		Serious Incident		Dat	е	15 July 2021				Tir	me 1020Z							
Type of Operation Private (Part 91)																		
Location																		
Place of Departure	\ (/irginia A FAVG)	erodrome	Place Land	e of I ing	Intendeo	d Kruger M Internati			Vpumalanga ional Airport (FAKN)								
Place of Incide	nt	KwaDukuza, about 16 nautical miles (nm) north of King Shaka International Airport (FALE)																
GPS Co-ordinates		Latitude	29.5"	Lor	ongitude E 031º 19' 07.			07.3	Elevation 2			29ft						
Aircraft Information																		
Registration		ZS-LRO																
Model/Make	Piper PA-28-140 Cherokee																	
Damage to Aircraft		None				Total Aircraft Hours			5	7155.8								
Pilot-in-command																		
Licence Type Priva		ate Pilot Licence (Aircraft)				Gender		Male			Age		18					
Licence Valid	Yes																	
Total Hours on Type		13.6				Total Flying Hours				91.6								
Pilot Monitoring																		
Licence Type	nmercial Pilot Licence (Aircraf				t) Gender		Female			Age		26						
Licence Valid	Yes																	
Total Hours on Type		18.1				Total Flying Hours				459.1								
People On-board		2 + 2	Injuries	0	Fa	Fatalities 0 Other (on ground				und)	0							
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What Happened

On 15 July 2021 at about 0915Z, two pilots accompanied by two passengers on-board a Piper PA-28-140 Cherokee aircraft with registration ZS-LRO departed Virginia Aerodrome (FAVG) on a private flight to Kruger Mpumalanga International Airport (FAKN). The pilot seated on the left seat was the pilot flying (PF), and the pilot seated on the right seat was the pilot monitoring (PM). The PF had a Private Pilot Licence (PPL), and the PM had a Commercial Pilot Licence (CPL).

According to the PF, who was piloting the aircraft at take-off, the cockpit instruments were functioning normally during take-off and climb; however, approximately 20 minutes into the flight whilst cruising at 1000 feet (ft) above ground level (AGL), the engine began to run rough, followed by a slight reduction in the engine's revolutions per minute (rpm). The PM, who had taken over control of the aircraft at that stage, stated that because they were 16 nautical miles (nm) north of King Shaka International Airport (FALE), they decided to turn left to FALE for a precautionary landing, provided that the engine could still produce sufficient power.

The PM stated that while routing towards FALE, the engine continued to lose power and could not maintain the airspeed required to sustain the flight; and subsequently, the aircraft was rapidly losing altitude. After an unsuccessful fault-finding exercise as well as not being able to restore engine power, the PM contacted FALE tower on frequency 125.75-Megahertz (MHz) to notify them of their emergency. However, due to the rapid loss of altitude, the PM began scanning the area for a suitable place to land; she spotted a dirt road on a private farm which was on the left-side of the aircraft's path. The PM landed the aircraft successfully with no damages to the aircraft and no injuries to the people on-board.

What was found:

Post-incident examination of the engine's right-side magneto after it was removed from the engine revealed that 11 teeth of the nylon distributor gear were stripped. All teeth fragments were found inside the magneto housing. The magneto was cleaned, whereafter a new nylon distributor gear was fitted in accordance with (IAW) *Continental Ignition System Service Manual X42002-3* dated August 2011. The magneto was fitted to the engine, and the engine was test-run and found to be operating satisfactorily.

According to the Airworthiness Bulletin (AWB) 74-055 Issue 3 of 20 October 2014, there are several reasons that could cause the nylon distributor gear failure. The nylon or "plastic" distributor gears could suffer problems due to ageing, and suffer hardening of the gear material and fatigue cracking; tooth failures may also be attributed to:

- Prop strikes
- High temperature
- *Kick back during starting before fire events* (i.e., if the engine was started with both magnetos/right magneto)
- Magneto "locking devices" being left in the magneto
- Lightning strikes
- Incorrectly installed gears
- Any other event which could cause shock on the gear trains of the back gears and distributor gear (i.e., mishandling of distributor gear while being installed, thereby, damaging the teeth)

The magneto had operated for 114.33 hours since its time between overhaul (TBO), thus, the magneto had been in operation for 23% of the 500 hours TBO. There were no previous incidents or technical defects that were recorded in the aircraft documents that could have indicated that any of the above possibilities had occurred; thus, the cause of the nylon distributor gear failure was undetermined.

Probable cause:

Power loss due to right-side magneto failure in-flight because of the failure of the nylon gear, which led to the failure of the engine ignition system.

Safety Action

None.

Safety Message

To avoid injury or damage to property, pilots are advised to land at the nearest airport from where an emergency occurs, especially when they are experiencing an engine power loss and a rapid loss of height.

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Purpose of the Investigation

In terms of Regulation 12.03.1 of the Civil Aviation Regulations (CAR) 2011, this report was compiled in the interest of the promotion of aviation safety and the reduction of the risk of aviation accidents or incidents and **not to apportion blame or liability**.

About this Report

Decisions regarding whether to investigate, and the scope of an investigation are based on many factors, including the level of safety benefit likely to be obtained from an investigation. For this occurrence, no investigation has been conducted, and the Accident and Incident Investigations Division (AIID) has relied on the information submitted by the affected person/s and organisation/s to compile this brief report. The report has been compiled using information supplied in the initial notification, as well as follow-up information to bring awareness of potential safety issues to the industry in respect of this occurrence, as well as possible safety action/s that the industry might want to consider in preventing a recurrence of a similar accident.

This report provides an opportunity to share safety message/s in the absence of an investigation.

All times given in this report are Co-ordinated Universal Time (UTC) and will be denoted by (Z). South African Standard Time is UTC plus 2 hours.

Disclaimer

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This report is issued by:

Accident and Incident Investigations Division South African Civil Aviation Authority Republic of South Africa