## 1

**Aviation Safety Investigation Report 198903768** 

**Aero Commander 100** 

25 April 1989

Readers are advised that the Australian Transport Safety Bureau investigates for the sole purpose of enhancing transport safety. Consequently, Bureau reports are confined to matters of safety significance and may be misleading if used for any other purposes.

Investigations commenced on or before 30 June 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with Part 2A of the Air Navigation Act 1920.

Investigations commenced after 1 July 2003, including the publication of reports as a result of those investigations, are authorised by the CEO of the Bureau in accordance with the Transport Safety Investigation Act 2003 (TSI Act). Reports released under the TSI Act are not admissible as evidence in any civil or criminal proceedings.

NOTE: All air safety occurrences reported to the ATSB are categorised and recorded. For a detailed explanation on Category definitions please refer to the ATSB website at www.atsb.gov.au.

Occurrence Number: 198903768 Occurrence Type: Accident

**Location:** Mackay QLD

**Date:** 25 April 1989 **Time:** 1252

**Highest Injury Level:** Nil

**Injuries:** 

	Fatal	Serious	Minor	None
Crew	0	0	1	1
Ground	0	0	0	-
Passenger	0	0	0	0
Total	0	0	0	1

Aircraft Details: Aero Commander 100

Registration:VH-EXLSerial Number:114Operation Type:PrivateDamage Level:SubstantialDeparture Point:Bowen QLD

**Departure Time:** 1200

**Destination:** Mackay QLD

Approved for Release: 28th September 1989

## **Circumstances:**

During a visual approach to Runway 32 the engine began to run roughly, to the extent that no useful power was available. The pilot made a "Mayday" call and elected to attempt a forced landing on Runway 05. In the latter stages of the approach it became obvious to the pilot that the aircraft would not reach the runway. It flew into a tall sugar cane crop and overturned at low speed. The cane cushioned the final impact. Investigation revealed that both magnetos contained leaking, obsolete coils. They had overheated, causing the ignition to fail. The coils were clear case coils which should have been withdrawn from service in the early 1970's in accordance with a specific Airworthiness Directive (AD). The AD had been withdrawn when it was considered that Licenced Aircraft Maintenance Engineers (LAMEs) in the aviation industry were sufficiently aware of the hazards posed by these coils and that all in-service clear case coils had been replaced. At engine runup, both magnetos had checked serviceable because the coils were cold. During the flight, they had heated sufficiently to cause an internal breakdown of their function, resulting in a significant power loss. The pilot misjudged the subsequent forced landing and the aircraft undershot the runway threshold.

## **Significant Factors:**

The following factors were considered relevant to the development of the accident

- 1. The engine ignition system failed due to overheating magneto coils.
- 2. Breakdown of the coil insulation was due to age deterioration.
- 3. The pilot misjudged the forced landing approach.

## **Reccomendations:**

The documentation in regard to the relevant Airworthiness Directive (AD) is no longer available because it was withdrawn more than a decade ago. The AD was withdrawn after the aviation industry had been exposed to the directive for several years. Since this accident, several clear case coils have been found in aircraft involved in accidents. It has become apparent that . Clear case coils are still in service in some Australian aircraft; and . LAME's who qualified in the last decade may not be aware that these coils are obsolete. The recommendation is that the Civil Aviation Authority consider issuing an Airworthiness Directive to check all piston-engined aircraft for obselete, clear case coils at the next Periodic Inspection.