

Final Accident Report

Version number: 1

Date: 21 Aug 2026

By Ria Moothilal on behalf of SAHPA / SACAA

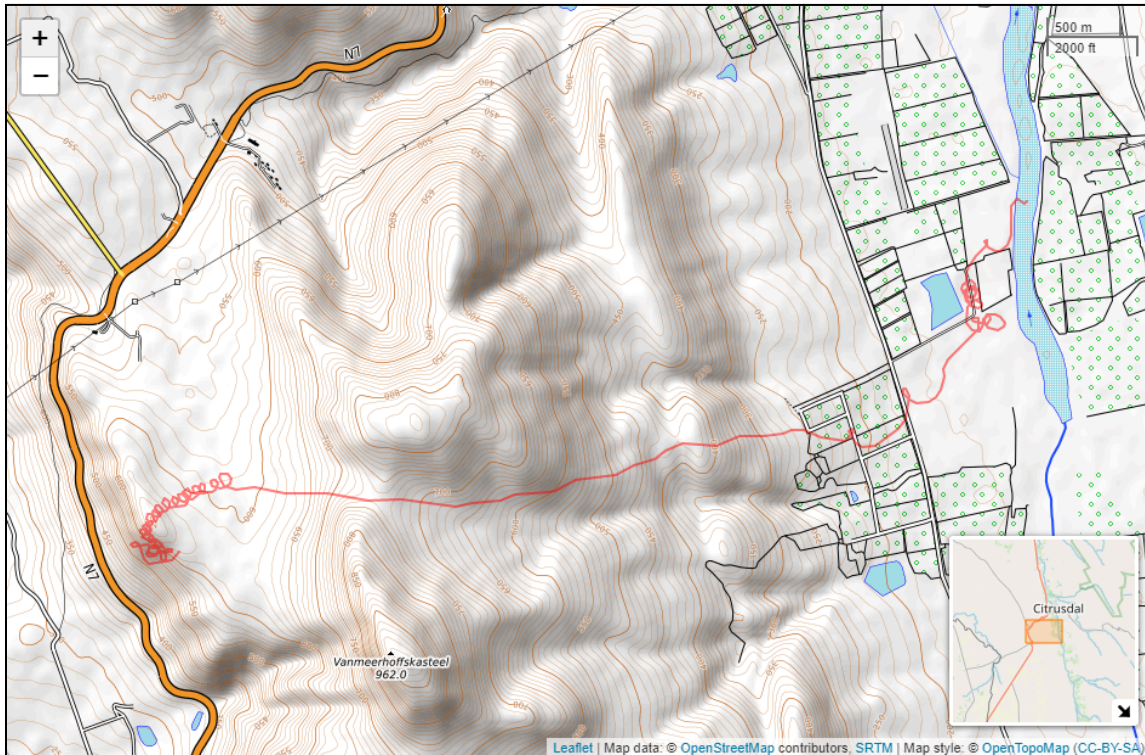


Figure 1: Solo paraglider flight resulting in a fatal accident on the east side of Piekinierskloof Pass (N7) near the town of Citrusdal in the Western Cape

Description:

On 22 January 2025, an experienced paragliding pilot launched a solo cross-country flight from Kardoesie, near Citrusdal. After approximately 20 minutes of flying, the pilot experienced an in-flight loss of control and descended rapidly. He came to rest in the middle of the Olifants River, where he was found entangled in paraglider lines. The autopsy determined the cause of death to be drowning, with no significant traumatic injuries. Analysis of the flight tracklog indicates that a reserve parachute was likely deployed before water impact, and that entanglement during water immersion contributed to the pilot's inability to escape.

INTRODUCTION

Reference Number: SAHPA/148/10/02/2025

Manufacturer: UP Paragliders

Model: Guru

Nationality: South African

Registration Marks: NA

Place: 32°37'20.4"S 19°00'47.8"E

Date: Wed 22 Jan 2025

Time: 12h31 (local time)

Purpose of the Investigation:

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

Times given in this report are Coordinated Universal Time (UTC). South African Standard Time (SAST) is UTC plus 2 hours. Where local time is reported, it is denoted with a "SAST"

Investigation Process:

On 10 February 2025, the SAHPA Committee appointed the author of this report as the Lead Investigator for this accident. Various supporting documents and evidence were made available for the investigation. Additionally, information from other external sources was sourced. The available data is analysed in this document.

Notes:

1. Whenever the following words are mentioned in this report, they shall mean the following:

- Accident — This investigated accident*
- Aircraft — the paragliding craft involved in this accident*
- Investigation — the investigation into the circumstances of this accident*
- Pilot — the pilot involved in this accident*
- Report — this accident report*

2. Photos and figures used in this report were taken from different sources and may have been adjusted from the original to improve the clarity of the report. Modifications to images used in this report were limited to cropping, magnification, file compression, enhancement of colour, brightness, and contrast, or addition of text boxes, arrows, or lines.

Disclaimers:

- This report is produced without prejudice to the rights of SAHPA, which are reserved.*

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ABBREVIATION	DESCRIPTION
'	Coordinates minutes (distance)
"	Coordinates seconds (distance)
°	Degrees
°C	Degrees Celsius
AIID	Accident and Incident Investigations Division
ASL	Above Sea Level
CAR	Civil Aviation Regulations
EMS	Emergency Medical Service
GPS	Global Positioning System
IGC	File format specified by the International Gliding Commission
kph	Kilometres per hour
m	Metres
NPL	National Pilot License
RASP	Regional Atmospheric Soaring Prediction (www.rasp.org.za)
SACAA	South African Civil Aviation Authority
SAHPA	South African Hang-gliding and Paragliding Association
SIV	Safety Manouvers Training in Paragliding
XC	Cross-country
UTC	Coordinated Universal Time
SAST	South African Standard Time (UTC + 2 hours)

1. Factual Information

1.1 History of Flight

A paragliding pilot launched on a solo cross-country paragliding flight on the morning of 22 January 2025 using a UP Guru glider. This was his **second flight of the day**. His first flight launched from the **Kardoesie takeoff site** at approximately **08:54 UTC**, but was unsuccessful as a cross-country attempt. He later relaunched from the **same site** for a second attempt at **10h12 UTC (12h12 SAST)**.

The GPS tracklog from the second flight showed standard thermalling followed by transition into XC glide. The flight lasted approximately 20 minutes before a sudden and rapid loss of altitude began from a point **~240 m above the Olifants River**. The final descent, marked by a steep drop from 440 m ASL to ground level (200m ASL) over **~45 seconds**, ended with the pilot entangled in his wing, face down in the centre of the river. His body was recovered in the early morning of 23 January.

1.2 Injuries to Persons

Injuries	Pilot	Passengers	Total
Fatal	1	-	1

1.3 Damage to Aircraft

The UP Guru S glider was significantly damaged. Lines were cut or missing, and canopy integrity was compromised during recovery. Glider inspection was inconclusive due to the post-accident condition.

1.4 Personnel Information

- **Age:** 66
- **License:** PG Sport, Grade C Instructor
- **Experience:** Extensive cross-country flying experience and licensed tandem paragliding instructor

B. RENEWAL CHECKLIST:			
Current license(s)		TFI PG, SPORT, TANDEM Glider(s) GIN FUSE 3, BOOMER 12	
(Copy of logbook(s) with a name and licence number detailed showing summary for the past year's flights must be attached)			
PG flights flown during past year	110	Total PG flights since commencing sport	13212
PG hours flown during past year	268	Total PG hours since commencing sport	5883
Tandem PG flights flown during past year	1666	Total Tandem PG flights since commencing sport	8434
Tandem PG hours flown during past year	151	Total Tandem PG hours since commencing sport	1231

Figure 2: License renewal information as of 23 May 2024

- **Flight Volume:** Estimated 1500+ instructional tandem flights annually. Estimated ~100 solo flights (~250hrs) annually.
- **Recent Events:** On the 30th November 2024, the pilot experienced a reserve deployment in the Northern Cape. He retired the glider (Gin Boomergang 12) afterwards. The pilot verbally expressed doubt about continuing solo XC flying with the author of this report, as well as other pilots working at Signal Hill. He was flying a 2019 UP Guru S at the time of the fatal flight.
- **Online Flight Logging:** The pilot uploaded his flights to the [XContest.org](https://xcontest.org) website. This is common practice with many XC paragliding pilots. The uploaded flights provide insight into the flying history preceding the accident. Whilst it is possible that the pilot performed solo flights not logged on X-Contest, it's unlikely that these were XC flights as his uploading of flights appear to be a standard procedure for his XC flying.
NB. Communication with family members reports that the pilot did a few flights during the winter months that were not captured on XContest, with evidence of these flights available on platforms such as Facebook.

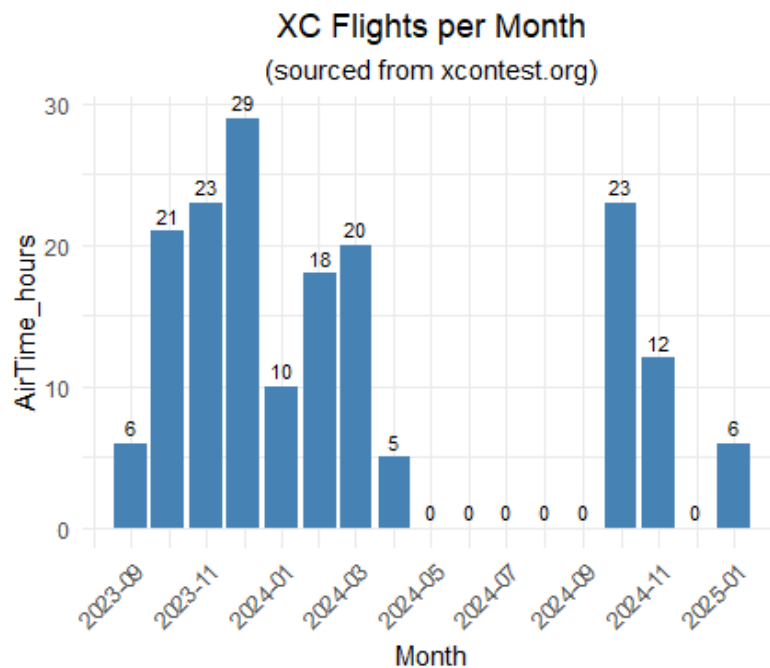


Figure 3: Cumulative monthly summary of solo XC airtime for the past 3 XC seasons

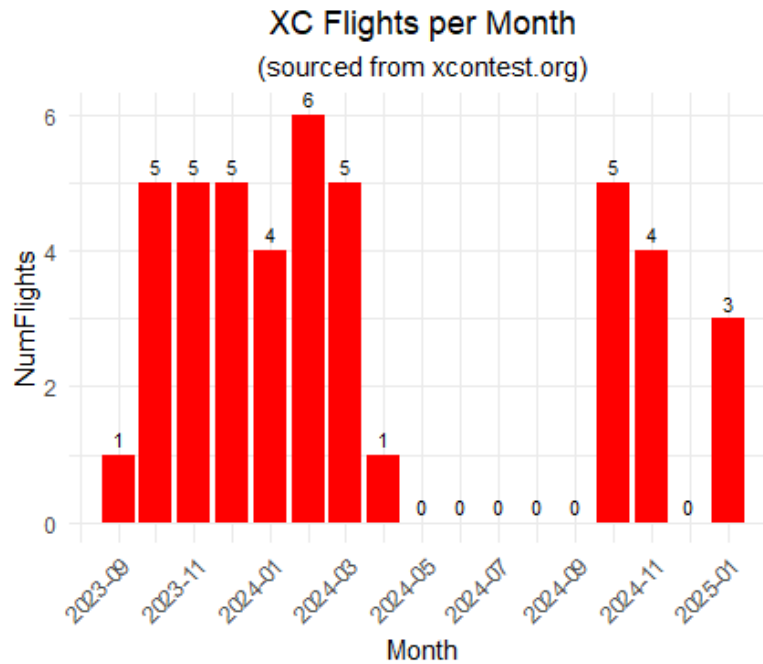


Figure 4: Cumulative monthly summary of the number of solo XC flights for the past 2 XC seasons

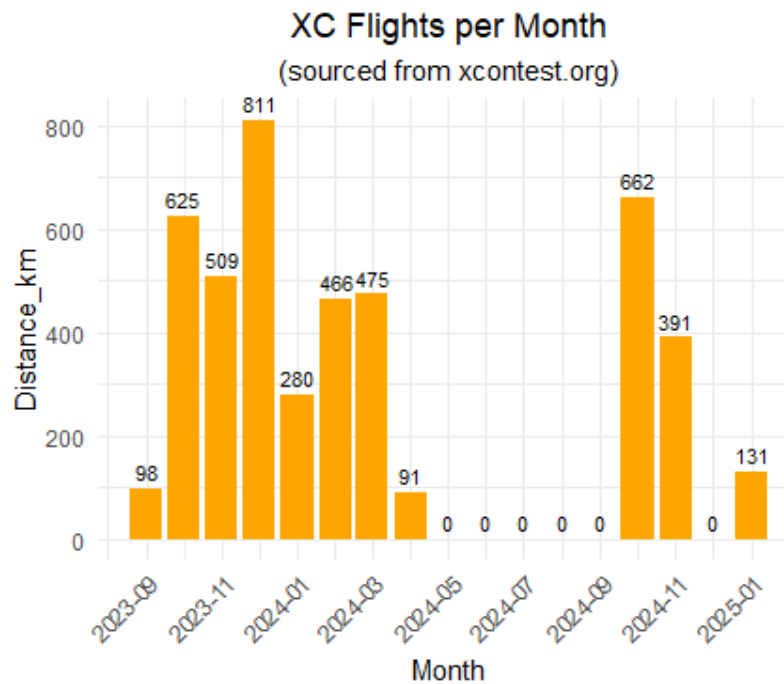


Figure 5: Cumulative monthly summary of solo XC distances for the past 3 XC seasons

1.5 Aircraft Information



Figure 6: Photo captured at the start of the flight (source Facebook)

1.5.1 Glider

- Model: UP Guru S (Serial number: XD90-03-1-18B-8118)
- Certification: CCC
- Manufacture: 2019
- Condition: Formal porosity check post accident shows the glider porosity to be "Like New"
- Maintenance: No trim check records available for investigation

1.5.2 Harness

- Gin Genie Race 4 Pod Harness
- Webbing cut during body retrieval
- Harness was equipped with **Charlie Quick-Outs on the risers**
- **One riser was found to be released via the Quick-Out**, indicating that the pilot **consciously released** it either during reserve deployment or while in the water

Specifications

Size	S	M	L
Harness weight (kg)*	8.5	8.7	9.2
Pilot height (cm)	160-175	170-185	>180
Removable foot plate (kg)	0.31	0.36	0.39

Table 1: Harness size specifications

1.5.3 Rescue Parachute

- Reserve suspected to have been deployed
- Bridles were cut, and the reserve was not recovered, preventing verification

1.5.4 Other Equipment

- Helmet found ~5–10 m upstream of accident, **unclipped** and intact. A GoPro camera was attached to the helmet, but it did not contain any record of the incident.
- One boot and a cap were found downstream

1.6 Meteorological Information

Forecast Variable	Forecast Local Standard Time			
	0800	1100	1400	1700
Boundary Layer Cloud (%)	0	0	0	0
Boundary Layer Height (m)	447	2003	2663	1036
Boundary Layer Wind Direction (deg)	345	343	305	269
Boundary Layer Wind Speed (kph)	7	11	15	24
Thermal height (m)	439	1459	1961	439
Surface Dewpoint Temp (deg)	16.5	14.3	16.1	17.8
Surface Sun (%)	100	100	100	100
Surface Temperature (deg)	25.1	32.6	34	29.8
Surface Wind Direction (deg)	345	264	254	274
Surface Wind Speed (kph)	9	7	15	20
Average Thermal Strength (m/s)	0	2	2	1

Table 2: Weather forecast for the Kardoesie takeoff site sourced from RASP.org.za as forecast on the morning of the accident

- Weather Actual: The photo in Figure 6 shows a sunny, blue sky day, typical for this region in summer.
- Weather Forecast: The forecast from the RASP weather model (Table 2) shows an average summer day with medium-strength thermals and full sunshine. Surface wind forecast was 7kph and 15kph at 11h00 SAST and 14h00 SAST, respectively.
- Thermal drift calculations at the start of the flight provided a wind speed and direction of **9.8kph from 237 degrees**
- The river water was calm and slow-moving at the time of recovery - the rescue diver found it easier to start from a downstream position (due to easier access through the river foliage) and swim upstream to the accident scene.

1.7 Aids to Navigation

- Naviter, Oudie N Variometer: IGC tracklog recorded full flight details.
- Satellite tracker: Final ping matched accident location

1.8 Communication

- No VHF or two-way radio reported, though it's quite likely he had one, as was standard practice for his XC flights
- No evidence of an emergency call or Mayday from the pilot

1.9 Aerodrome Information

- Take off from the Kardoesie launch site, which is a SAHPA-registered site located on the west side of the Piekinierskloof Pass near the town of Eendekuil in the Western Cape
- The accident took place in the free-flying region south of the town of Citrusdal

1.10 Flight Recorders

- IGC tracklog confirms:
 - Altitude gain to ~1280 m
 - Controlled descent before sudden drop

1.11 Wreckage and Impact Information

- Body found beneath a collapsed canopy in the river centre
- Legs tightly entangled in lines

- The body was found with a harness and “parachute” attached

1.12 Medical and Pathological Information

- Cause of death: Drowning
- No traumatic injuries or external wounds
- A faint contusion was noted on the deep scalp over the frontal skull area; no fractures were present.
- According to the autopsy report: *“Multiple ropes, reportedly belonging to the paragliding gear, were tightly wrapped around the lower legs and ankles”*
- A follow-up discussion with the official pathologist on 9 October 2025 confirmed that the autopsy findings do not support the hypothesis that the pilot was unconscious before entering the water. The presence of emphysema aquosum indicates the pilot was breathing after submersion.

1.13 Fire

- None

1.14 Survival Aspects

- The helmet was found in an **unclipped** state.
- Rescue swimmer observed significant drag due to canopy entanglement
- Recovery environment: Calm river, no strong current, deceptive depth near shore - estimated 6-8m river depth with a sharp drop from the river bank. **Dense reeds were present along the river banks.** The section of the river was approximately 10m to 15m wide.

1.15 Tests and Research

- Post-accident glider inspection confirmed a canopy with very good porosity results.
- A voice message from the pilot to a fellow community member stated concerns about the glider's porosity, which was not in line with official post-accident inspection results.
- A single riser was released using the quick-out system present with the glider.
- Inspection inconclusive due to incomplete line system and reserve absence
- Tracklog analysis confirms normal thermalling flight before the event, a rapid loss of altitude, followed by a change in descent characteristics.
- Based on the terrain and the investigation site visit, the bruising described in the pathology report was not consistent with impact against rocks. The terrain in the vicinity is free of rocks and large trees. It consists mostly of reeds and softer

shrubs.

1.16 Additional Information

- The investigator conducted interviews with the entire first responder team, as well as telephonic conversations with the pathologist and the pilot's family members.
- First responder accounts confirm:
 - Dense vegetation obstructed access
 - The GPS pin was slightly off from the body location
 - Body discovered at ~02:00 SAST –03:00 SAST on 23 January
 - Ropes attached to the glider made it very difficult to pull the body towards the shore, so they cut the lines and retrieved the body. The glider was later retrieved during daylight hours.
- The body was initially found using a drone from a local security company. This same drone operator then found the pilot's helmet, shoe and a cap two days later while flying the drone in the vicinity of the accident.
- Historical context: The pilot had voiced the intention to reduce solo XC flying after a reserve deployment earlier in the summer season (approximately two months before the accident). This statement was made by the pilot in direct communication with the author of this report, as well as confirmed by other tandem flight instructors who worked alongside the pilot at Signal Hill.

2. Analysis and Findings

2.1 Tracklog analysis

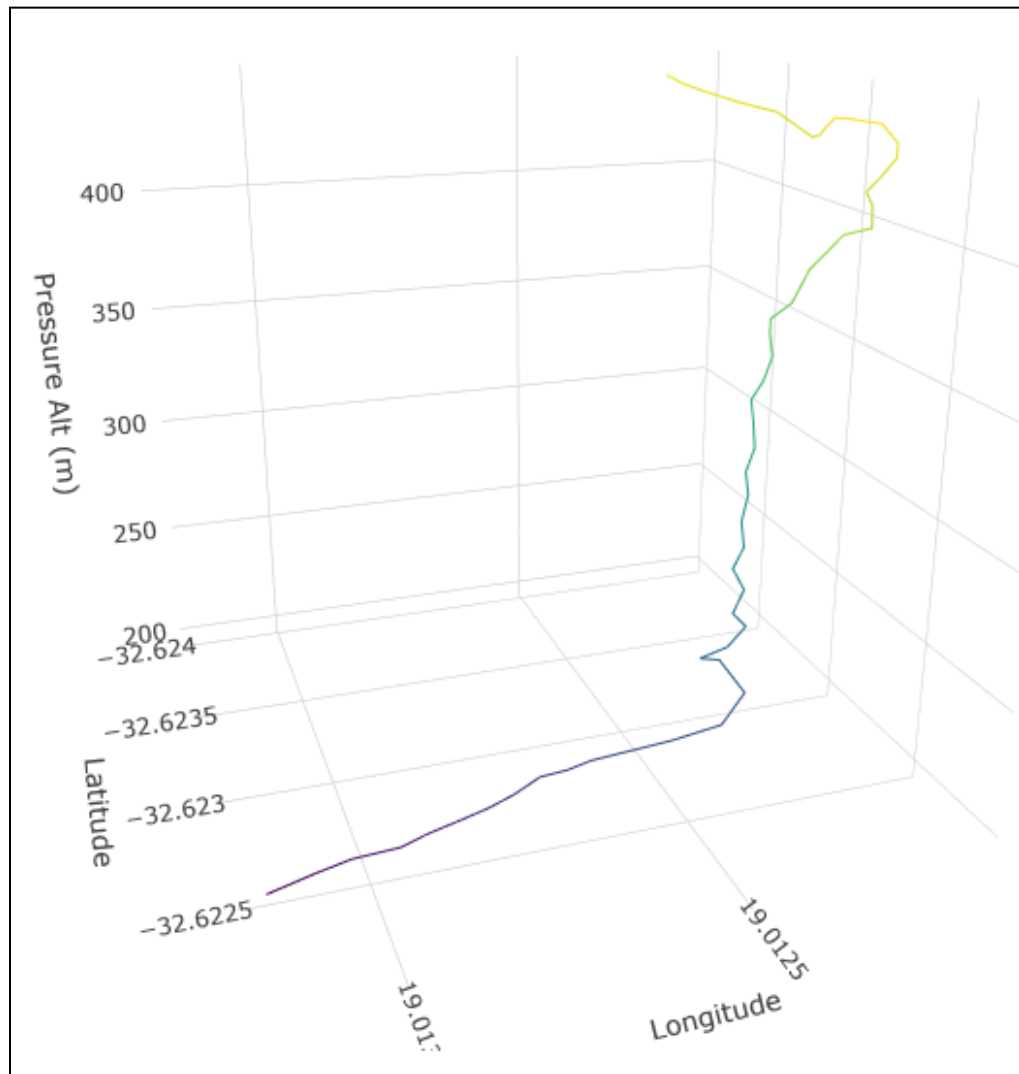


Figure 7: 3D flight path analysis in the last 60 seconds of flight

	timestamp	lat	lon	pressure_alt	gps_alt	dt	dPressAlt	vario	climb_type
1	10:30:56	-32.62397	19.01222	440	421	1	-1	-1	Sink
2	10:30:57	-32.62383	19.01222	438	419	1	-2	-2	Sink
3	10:30:58	-32.62372	19.01220	436	416	1	-2	-2	Sink
4	10:30:59	-32.62360	19.01217	433	413	1	-3	-3	Sink
5	10:31:00	-32.62345	19.01213	431	410	1	-2	-2	Sink
6	10:31:01	-32.62330	19.01213	427	407	1	-4	-4	Sink
7	10:31:02	-32.62312	19.01217	427	408	1	0	0	Neutral
8	10:31:03	-32.62297	19.01220	431	412	1	4	4	Climb
9	10:31:04	-32.62283	19.01223	436	417	1	5	5	Climb
10	10:31:05	-32.62273	19.01225	441	421	1	5	5	Climb
11	10:31:06	-32.62267	19.01225	442	422	1	1	1	Climb
12	10:31:07	-32.62260	19.01222	441	420	1	-1	-1	Sink
13	10:31:08	-32.62257	19.01220	435	414	1	-6	-6	Sink
14	10:31:09	-32.62257	19.01220	430	410	1	-5	-5	Sink
15	10:31:10	-32.62255	19.01223	424	405	1	-6	-6	Sink
16	10:31:11	-32.62255	19.01225	420	399	1	-4	-4	Sink
17	10:31:12	-32.62252	19.01225	416	394	1	-4	-4	Sink
18	10:31:13	-32.62247	19.01227	410	389	1	-6	-6	Sink

Table 3: Selected tracklog data (Time in UTC)

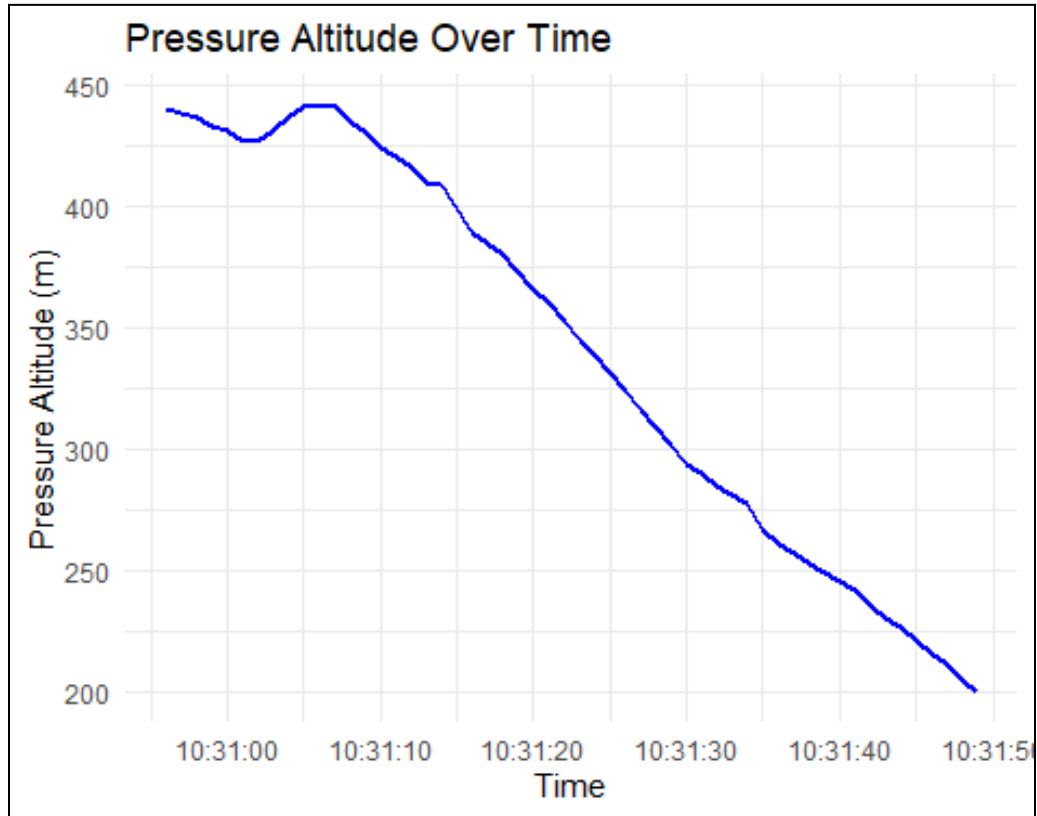


Figure 8: Tracklog data showing height over time (Time in UTC)

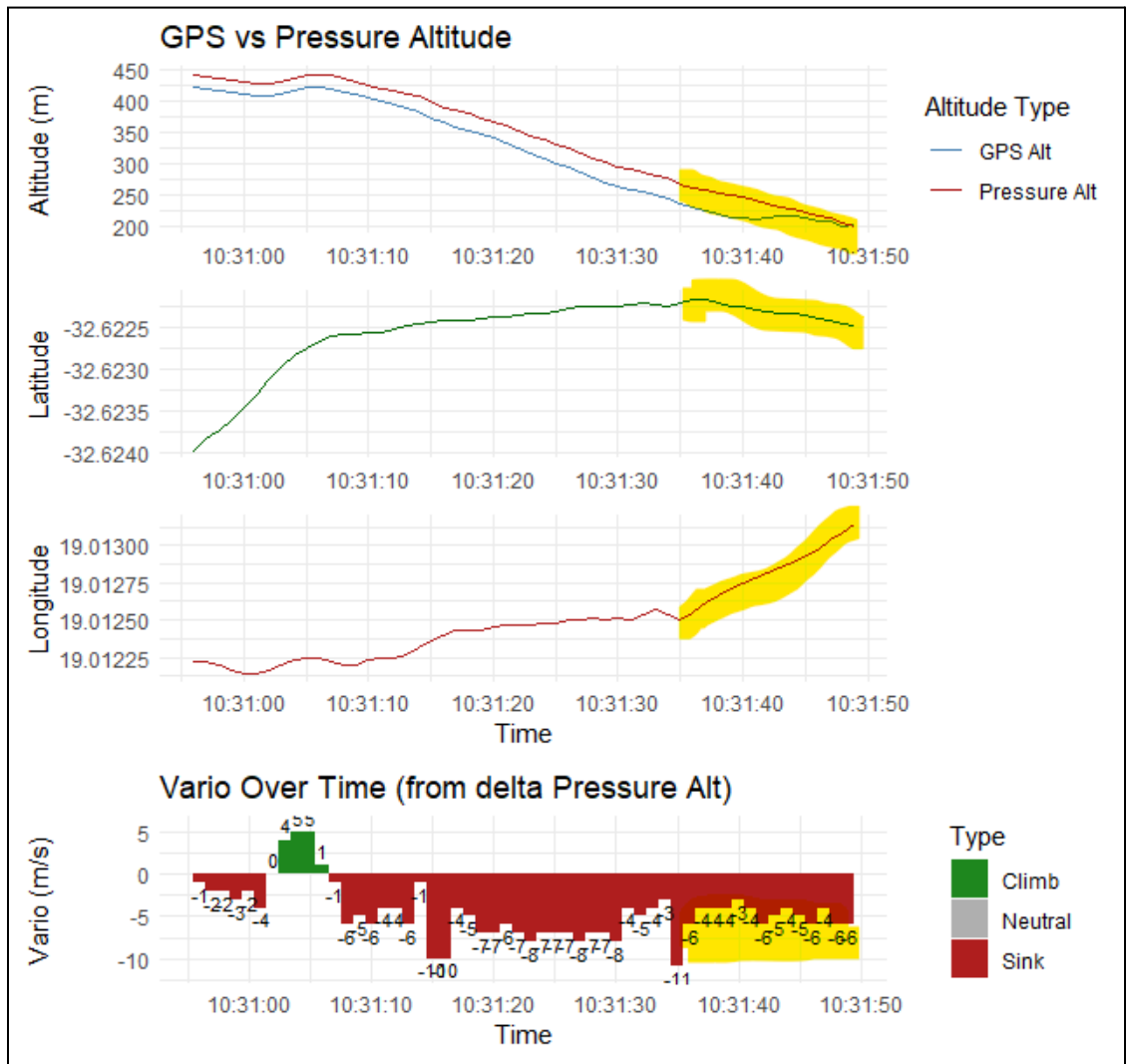


Figure 9: Tracklog data plotted by time. Areas highlighted in yellow are deduced to be those under which the reserve parachute was deployed (Time in UTC).

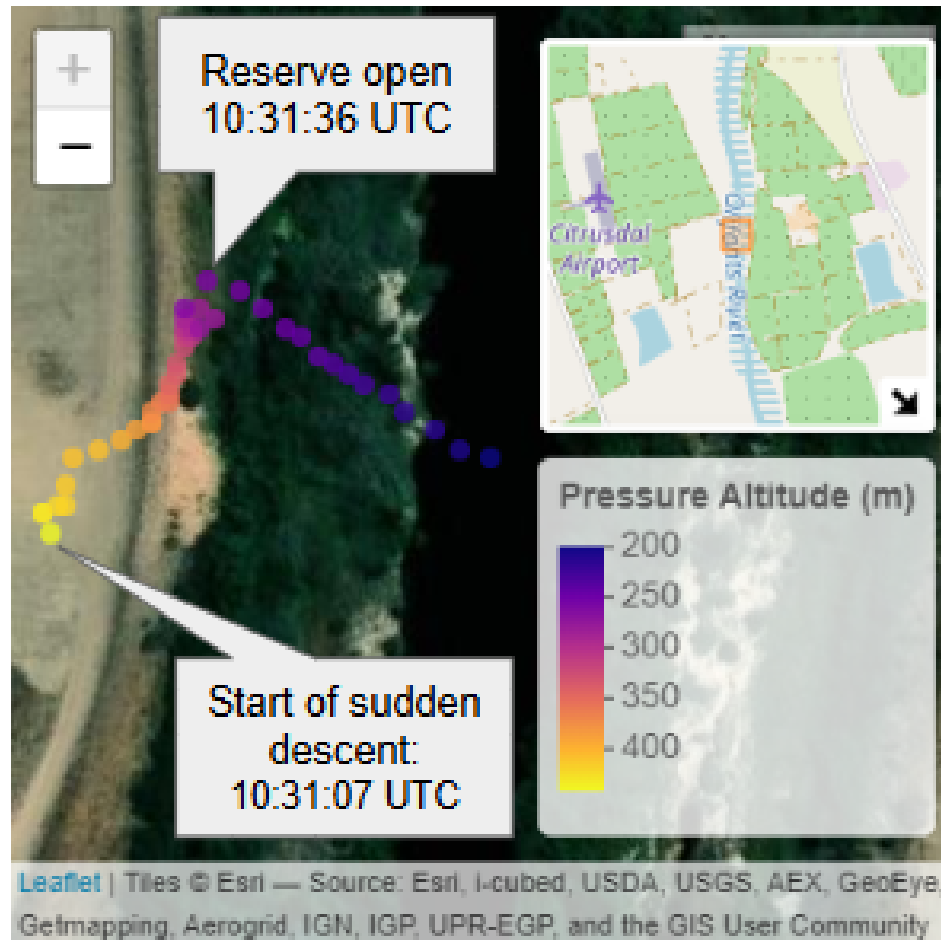


Figure 10: Tracklog positional data plotted on a map from 10:31:07 UTC to 10:31:49 UTC

	timestamp	lat	lon	pressure_alt	gps_alt	dt	dPressAlt
48	10:31:43	-32.62232	19.01285	231	215	1	-5
49	10:31:44	-32.62233	19.01288	227	216	1	-4
50	10:31:45	-32.62235	19.01293	222	214	1	-5
51	10:31:46	-32.62238	19.01297	216	209	1	-6
52	10:31:47	-32.62242	19.01303	212	208	1	-4
53	10:31:48	-32.62245	19.01308	206	200	1	-6
54	10:31:49	-32.62247	19.01315	200	202	1	-6
55	10:31:50	-32.62248	19.01317	221	206	1	21
56	10:31:51	-32.62248	19.01318	83	207	1	-138
57	10:31:52	-32.62247	19.01322	63	209	1	-20
58	10:31:53	-32.62245	19.01325	24	212	1	-39
59	10:31:54	-32.62243	19.01325	45	218	1	21
60	10:31:55	-32.62238	19.01325	34	221	1	-11
61	10:31:56	-32.62232	19.01328	-5	222	1	-39

Table 4: Traklog position data. Rows highlighted in yellow are deduced to be those under which the reserve parachute was deployed (Time in UTC).

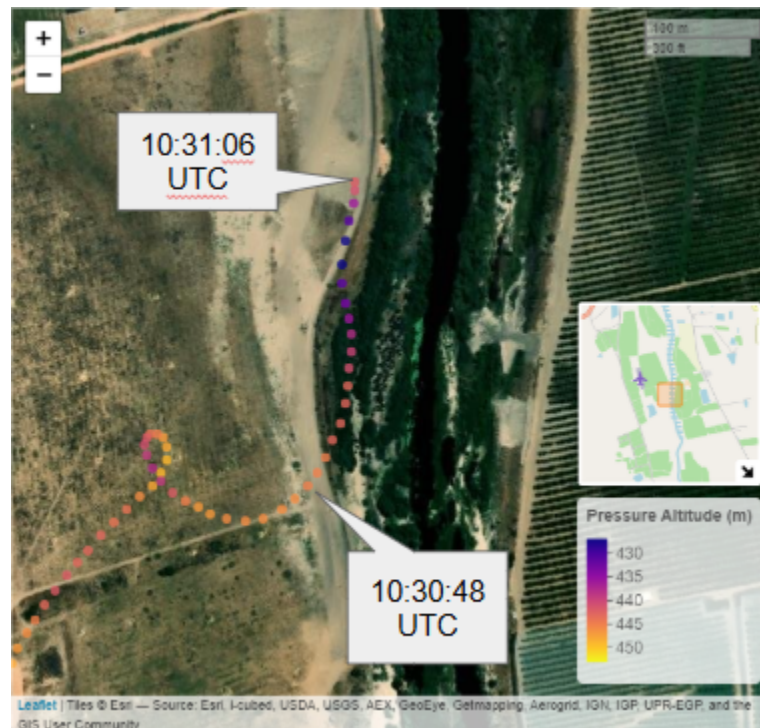


Figure 11: Pilot flies parallel and alongside the river at an altitude of ~240m AGL from 10:30:48 UTC to 10:31:06UTC (before the start of the sudden descent)

- The detailed flight path information extracted from the IGC file shows that the pilot was flying in a typical search pattern for a thermal before the incident.
- Between 10:30:48 UTC and 10:31:06 UTC, he flew parallel, upwind, and alongside the Olifants River at an altitude of ~240m AGL
- He started to climb quite strongly (4-5m/s) at 10:31:03 UTC for 4 seconds before encountering strong sink (4-6m/s), which got stronger, averaging 7m/s loss of altitude for the next few seconds before a peak of 11m/s sink at 10:31:35 UTC (See table 3 and figures 7 & 8).
- From 10:31:36 UTC, the sink rate varies around 4-6m/s along with a consistent change in latitude and longitude (see figures 9 & 10). These numbers are consistent with behaviour seen during reserve parachute descent.
- From 10:31:50 UTC (see table 4), there is a very abrupt increase in pressure altitude for a single reading, followed by a significant sustained reduction in pressure altitude. It suggests that this would have been the time at which the variometer impacted and then was submerged in the water

2.2 Rescue Deployment

- Tracklog analysis suggests that the pilot was under reserve for approximately **14 seconds** (from 10:31:36 UTC to 10:31:49 UTC), losing an altitude of **61m** before water impact.
- **Manual release of one Quick-Out riser** suggests a deliberate action to separate from the main glider, potentially while under reserve or entangled in water. NB. Release of the single riser is a possible cause of the contusion noted on the pilot's frontal skull area in the autopsy report.
- The deployed reserve, as well as the still-attached main glider, would have resulted in a significant amount of material and lines that would have hindered the pilot's efforts to self-extract from the river.

2.3 Pilot Skills and Human Factors

- Highly experienced with an active tandem flying schedule.
- The pilot was known to fly big cross-country flights lasting several hours each. From his last license renewal, a figure of ~250 annual solo hours implies that this pilot was highly skilled and comfortable in the thermal flying environment. According to the glider user manual, at least 150 annual hours are recommended. Skills and experience are as expected from a pilot flying the class of glider chosen.
- A notable drop in solo flying was observed in **December 2024**, with no XC flights logged for the entire month. This stands in contrast to **December 2023**, during which the pilot logged five substantial cross-country flights totalling over 800 km and nearly 29 hours of airtime. The December 2024 absence followed the reserve deployment incident in late November and suggests a **temporary withdrawal** from solo flying — potentially for recovery, reflection, or due to

diminished confidence. The lack of consistent solo thermic exposure during this key summer month may have affected sharpness and readiness in high-demand flight scenarios, although no evidence of degraded in-flight decision-making was observed.

- Following the November 2024 reserve deployment incident, the pilot logged three relatively short solo cross-country flights ranging from 32 to 53 km and under 2 hours each. This contrasts with his previous flights, which often exceeded 4 hours and 100 km. While these shorter flights confirm that the pilot resumed solo XC activity, they may also reflect a phase of recalibration, caution, or reduced psychological readiness for high-demand flight conditions.
- The decision to relaunch after an earlier unsuccessful XC attempt would be standard procedure for an XC flying day.
- The evidence speaks to a reserve being deployed with sufficient altitude to not have a fatal/serious accident due to non-deployment.
- Water landings - the pilot was vocal in the community about the dangers of water, having had a negative experience during an SIV training session earlier in his career. It is conceivable that this experience added to a state of panic when the pilot ended up landing in the middle of the river.
- The route selection was consistent with standard XC patterns and did not raise concerns at the time. Crossing or flying in the vicinity of the river would not have been a factor in his in-flight decision-making due to the river being sufficiently narrow to not appear as a possible hazard, especially from 240m+ above ground level. However, it should be noted that he did fly parallel to the river on the upwind side between 10:30:48 UTC and 10:31:06 UTC
- Based on terrain inspection and river geometry, this section of deep water is one of the few locations where a reserve descent could result in immersion. It is conceivable that an earlier or even later reserve deployment may have resulted in a different outcome.
- Although the reserve was deployed successfully, the pilot may have experienced task saturation or panic upon realising a water landing was imminent. The failure to cut away both risers, activate a rescue beacon, or deploy the hook knife may reflect the overwhelming nature of such a scenario, particularly given prior negative experiences with water. These are plausible scenarios given the circumstances, but cannot be confirmed.
- The incident highlights that even narrow water bodies can pose severe survivability risks, particularly when compounded by harness buoyancy, entanglement, and canopy drag. This challenges the assumption that water hazards are only critical when large or fast-flowing.
- Based on post-mortem findings and the pathologist's verbal confirmation, there is no evidence that the pilot was unconscious before water entry. The manual release of the helmet and a riser suggests consciousness before water impact.

2.4 Equipment

- Consultation with various glider maintenance service providers across the country did not prove successful in finding any maintenance reports. As such, the glider trim reports are not available. Trim analysis post the accident was not possible due to lines being cut during the body retrieval process.
- While the porosity of the glider tested within normal limits, the lack of documented trim maintenance and incomplete line set meant that the trim condition could not be assessed.
- It is not possible to tell if the equipment state was a contributing cause to the in-flight issue that resulted in the rapid loss of altitude from 10:31:08 UTC to 10:31:25 UTC.
- The glider is rated CCC, which is the highest performance class in the paraglider certification standards. The glider user manual states that “*Wings in this class are characterised by their **demanding behaviour in case of in-flight disturbances.***”
- The pilot was flying a **harness that, on its own, weighed ~8.5kg**. Together with his other various items and clothing used for the flight, this harness would have weighed the pilot down quite heavily once submerged in the water.
- The pod harness’s back protection and inflated rear fairing would likely have presented significant difficulty to the pilot in keeping his head above water, whilst at the same time having his legs entangled in the lines.
- The pilot had taken the precaution of being equipped with a satellite tracking emergency alert system, which was not activated. It’s conceivable that he did not anticipate drifting into the river and then did not have time to activate any rescue call whilst trying to save himself from drowning. It is unlikely that a rescue call would have made any difference to the outcome of the accident.
- The additional precaution of using Quick-Out attachments to the risers also did not prove effective in completely releasing from the main glider. Insufficient time may have prevented separation from the glider; pilot awareness of the impending water impact is unknown and cannot be inferred.
- The harness was equipped with a hook knife, which was still in place, showing no attempt to use it. It’s conceivable that, once submerged in water with line entanglement, there was little time to access the knife
- The pilot had taken extra precautions in terms of the equipment choices for the flights he was undertaking.

2.5 Weather and Thermal Turbulence

- Before the rapid loss of altitude at the end of the flight, the pilot’s tracklog displays the behaviour of one searching for a thermal to climb and gain altitude.
- The rapid loss of altitude, preceded by several seconds of rapid altitude gain, suggests the presence of a **strong thermal**. It is not uncommon for strong summer thermals to have sharp edges between the areas of rising and sinking air. Strong thermal turbulence is a significant plausible contributing factor to the cause of the event that led to a rapid loss of altitude from 10:31:08 UTC.

3. Probable Cause and Contributing Factors

This section identifies the most likely immediate cause and key contributing factors to the accident, based on the overall weight of evidence. It should be read in conjunction with Section 2, which presents a broader, more exploratory analysis. Section 2 deliberately examines a wide range of plausible factors — including equipment status, pilot experience, recent flying history, environmental influences, etc — in order to ensure a comprehensive investigation. Not all factors discussed in Section 2 are carried forward into this section as contributing causes. However, their inclusion was necessary to rigorously eliminate or contextualise alternative hypotheses and avoid speculative reinterpretations in the future.

3.1 Probable Cause

The accident was caused by an in-flight loss of control of undetermined exact origin, most consistent with an aerodynamic collapse or other stability event, which resulted in the pilot deploying his reserve parachute. The reserve descent brought the pilot into a body of water, where immersion while entangled in glider lines prevented escape, leading to drowning.

3.2 Contributing Factors (to the accident sequence)

- The use of a **CCC-class paraglider**, whose recovery characteristics require high pilot workload, **may have reduced recoverability** if a collapse occurred.
- **Turbulent thermal conditions** present in the area at the time provide a plausible environment for an in-flight loss of control, although the precise initiating mechanism could not be determined.

3.3 Contributing Factors (to the fatal outcome)

- The pilot **descended into a water body**, where entanglement with lines during immersion impeded escape.
- The depth and bank structure of the river, combined with vegetation, bulky equipment, material and lines from both the main glider and reserve parachute, significantly reduced survivability following water immersion.

4. Recommendations

4.1 Hazard Avoidance/Reduction in Cross-Country Flying

- Although there is no indication that the pilot anticipated a water landing, this accident highlights an important general consideration for XC flying. Pilots are advised to factor in the location of hazards such as rivers, powerlines, or highways when flying at altitudes where reserve deployment may occur. In particular, pilots should attempt to minimise time spent upwind of such hazards, where a reserve descent in thermic or windy conditions may result in being drifted into the hazard. When proximity is unavoidable, transitioning to the downwind side of the hazard is encouraged to improve the odds of a safe landing zone in the event of an in-flight incident.

4.2 Gear Preservation

- The reserve parachute was not recovered, and the equipment damage during the body retrieval limited the evidence gathering and accident investigation process. It is recommended that SAHPA create a basic protocol to be shared with the rescue services immediately, as required for future incidents where recovery teams interact with paragliding equipment during rescue operations.

4.3 Dissemination of Safety Lessons

- SAHPA is advised to improve the visibility and accessibility of safety-critical findings from fatal accident investigations. This includes publishing accident reports, summarising findings, highlighting key lessons learned, and ensuring that this information is proactively shared with the pilot community through safety bulletins, briefings, license training, mentorship programs, and license renewal processes. The goal is to foster a culture of learning from incidents rather than forgetting them. This recommendation is made in the interest of systemic safety improvement and is not linked to any specific pilot action.