ORIGINAL

NE:05:sw

20 JUN 1958

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH PART VII OPNAVINST 3750.6B

THIRD ENDORSEMENT on NAAS Whiting AAR ser 6-58 concerning T-28B, BUNO 138252, accident occurring 30 April 1958, Pilot (b) (6) [redacted]

From: Chief of Naval Air Training
To: Chief of Naval Operations (Op-57)
Via: (1) Chief, Bureau of Aeronautics (Aer-512)
(2) Commander, U. S. Naval Aviation Safety Center

Subj: Aircraft Accident Report; forwarding of

1. Forwarded.

2. CNATRA does not consider the information contained in this report is sufficient to assign any cause factors. Accordingly it is requested that an addendum be submitted to this report when the results of the DIR is known. It is also requested that the addendum clairify the relationship between the slightly creeping brakes and the assignment of this as a cause factor in this accident.

3. Further comment is withheld pending receipt of the addendum to this Aircraft Accident Report.

M. R. Doughty
M. R. DOUGHTY
By direction

Copy to:
NAVAVSAFETYCEN (2)
CNABATRA
BAR, NAA, Inc., Columbus, Ohio
BAR, Curtiss-Wright Corp., Wood-Ridge, N.J.
Naval Liaison Officer, DFSR, Norton AFB, San Bernardino, Calif.
CO, NAAS Barin
BSO, NAS Pensacola
CO, NAAS Whiting (4)

ORIGINAL

NE2:05:dzc
5 JUN 1958

SPECIAL HANDLING REQUIRED IN ACCORDANCE WITH OPNAV INST 3750.6B

SECOND ENDORSEMENT on NAAS Whiting AAR ser 6-58 concerning T-28B, BuNo 138252, accident occurring 30 April 1958, Pilot [redacted]

From: Chief of Naval Air Basic Training
To: Chief of Naval Operations (Op-57)
Via: (1) Chief of Naval Air Training
(2) Chief, Bureau of Aeronautics (AER-512)
(3) Director, Naval Aviation Safety Center

Subj: Aircraft Accident Report; forwarding of

1. Forwarded, concurring in the conclusions and recommendations of the Aircraft Accident Board and corrective action of the First Endorsement except as noted herein.

2. The primary cause factor of pilot error is not concurred in. Although the pilot did use poor judgement in accepting an aircraft for flight with weak brakes, this factor did not cause the engine malfunction and aborted take-off. The history of this aircraft from the period of X April 1958 when the brake pucks on the left wheel were changed indicates a plane that should have been scheduled for a Maintenance Test Flight or a Dual Syllabus Flight with an experienced pilot rather than an inexperienced Solo Student.

3. The instructor should have given the student definite instructions when asked for advice concerning the students brake difficulties. With no other discrepancies, a good power and magneto check at 30" Manifold Pressure, the desire to complete a scheduled training flight and not cause a canceled hop possibly influenced the student to consider the plane satisfactory.

4. Under Part IX of the report concerning contributory factors, Para. 3(a) is considered to be the primary cause factor with Supervisory Error as Secondary Cause and Pilot Error a contributing factor.

2

5. Corrective action outlined in the Maintenance Officers Statement, Encl. (3), should prevent future similar occurrences.

6. Inadequate end zone and overrun conditions in the Basic Training Command is under advisement, but current funds available are a limiting factor.

ORIGINAL

ORIGINAL

7. The Chief of Naval Air Basic Training Maintenance Department is conducting an intensive campaign to discover and eliminate the current engine malfunctions associated with the R1820-86 under high usage training requirements. Engine analyzers are being used with great success in the program.

G. P. NORMAN
Chief of Staff

Copy to:
BUAER (AER-512) (2)
NAVAVSAFTYCEN (2)
BAR, NAA, Inc., Columbus, Ohio (1)
BAR, Curtiss-Wright Corp., Wood-Ridge, N. J. (1)
Naval Liaison Officer, DFSR, Norton AFB, San Bernardino, Calif. (1)
CO, NAAS Barin Field (1)
TGC, BSG, NAS Pensacola (1)
CO, NAAS Whiting Field (4)

ORIGINAL

ORIGINAL

0/jms

MAY 20 1958

FIRST ENDORSEMENT on NAAS Whiting Field AAR ser 6-58 concerning T-28B, 138252, accident occurring 30 April 1958, Pilot (b) (6)

From: Commanding Officer, NAAS Whiting Field
To: Chief of Naval Operations (Op-57)
Via: (1) Chief of Naval Air Basic Training
(2) Chief of Naval Air Training
(3) Chief, Bureau of Aeronautics (AER-512)
(4) Director, U. S. Naval Aviation Safety Center

Subj: NAAS Whiting Field Aircraft Accident Report 6-58; forwarding of

Ref: (a) CO NAAS Whiting Field ltr 094/ab of 12 May 1958

1. Forwarded, concurring with the conclusions and recommendations of the Aircraft Accident Board.

2. All pilots at NAAS Whiting Field are advised of the necessity for downing aircraft that are not, in all respects, safe for flight, and this policy will be re-emphasized. In addition, the requirement that the canopy be opened and fuel ignition switches turned off when a crash appears inevitable will be brought to the attention of all pilots again.

3. Maintenance personnel have been directed to insure that a complete engine turn-up and power checks be given all aircraft when turned up for engine conditioning.

4. A standard communication system between tower operators and crash crews has been established, and tower operators have been advised of the requirement for constant vigilance at all times while aircraft operations are in progress.

5. Reference (a), submitted in reply to BUAER Notice 1132 of 10 April 1958, reiterated previous reports of the inadequacy of runway over-runs at South Whiting Field.

6. N/C (b) (6) had had no previous accidents while attached to this command. His pilot history is contained in Section A, part 12, page 1 of the basic report.

D. J. Harrington
D. J. HARRINGTON

4

ORIGINAL

AIRCRAFT ACCIDENT REPORT
OPNAV FORM 3750-1 (REV. 11-55)
PAGE 1

SPECIAL [illegible] IN ACCORDANCE WITH OPNAV INST. [illegible].6B

See instructions for completion prior to filling out

OPNAV REPORT 3750-1

PART I – GENERAL

SECTION A – IDENTIFICATION

1. AIRCRAFT ACCIDENT BOARD CONVENED BY: CO, NAAS Whiting Field
2. DATE OF ACCIDENT / TIME: 30 April 1958 / 1242S
3. AAR SERIAL NO.: 6-58
4. TO: CHIEF OF NAVAL OPERATIONS (Op-57)
5. ENCLOSURES: (1) Pilot's Statement (2) Witness Statements (3) Maintenance Officer's Statement (4) Photographs (5) Sketch of Ditch (6) Medical Officer's Report (cc CNO, CNATRA, CNABATRA) (7) (8) (9)
6. VIA: (1) C.O. NAAS Whiting Field (2) CNABATRA (3) CNATRA (4) CHIEF BUAER (AER-512) (5) (6) (LAST) DIRECTOR, U. S. NAV. AV. SAFETY CENTER
7. REPORTING CUSTODIAN (if different than item number 1):
8. ACTIVITY OPERATING AIRCRAFT (if different than item 7): NAAS Whiting Field
9. KIND OF FLT.: 1D1
10. TIME OF DAY: ☐ DAWN ☒ DAY ☐ DUSK ☐ NIGHT
11. LOCATION OF ACCIDENT: South Whiting Field
12. ELEV. ABOVE SEA LEVEL: 178 ft.
13. PLACE OF LAST TAKE-OFF: South Whiting Field
14. CLEARED FROM South Whiting Field TO Local
15. TYPE CLEARANCE: ☐ IFR ☒ VFR ☒ LOCAL ☐ OPERATIONAL ☐ AIRWAYS ☐ DIRECT ☐ OTHER, Specify
16. TIME IN FLT.: 0+01
17. TYPE ACCIDENT: P-1-Aborted takeoff ran off end of runway.
18. PHASE OF FLIGHT: Code-3 Takeoff

AIRCRAFT

19. MODEL: T28B
20. SERIAL NO.: 138252
21. DAMAGE TO AIRCRAFT: ☒ A. ☐ B. ☐ C. ☐ D.
22. DOL. COST: 151,000.
23. AIRSPEED (kts): 50
24. A/C WT.: 8000
25. LIST MODEL, SER. NRS, REPORTING CUSTODIAN AND DAMAGE CLASSIFICATION OF ANY OTHER A/C INVOLVED (complete separate OPNAV Form 3750-1 for each A/C): None

SECTION B – PERSONNEL INFORMATION

PILOT AND CO-PILOT

1. PERSONNEL	2. NAME (last, first and middle initial)	3. RANK RATE	4. FILE SERV. NO.	5. DESIG-NATOR	6. DATE DESIG-NATED	7. DATE OF BIRTH	AGE
PILOT (PERSON AT CONTROLS AT TIME OF ACCIDENT)	(b) (6) [redacted]	N/C	(b) (6) [redacted]	NA	SNA	(b) (6) [redacted]	
CO-PILOT	None						

8. PERSONNEL	9. OPERATIONAL FLT. TRAINER: AVAILABLE?	USED?	10. UNIT TO WHICH ATTACHED	11. TYPE INSTRUMENT CARD
PILOT	☒ YES ☐ NO	☒ YES ☐ NO	BTG-3S NAAS Whiting Field	☐ STANDARD ☐ SPECIAL None
CO-PILOT	☐ YES ☐ NO	☐ YES ☐ NO	None	☐ STANDARD ☐ SPECIAL

12. PILOT, CO-PILOT, STUDENT EXP.

TOTAL PILOT HOURS	PILOT	CO-PILOT	STUDENT	ITEM	PILOT	CO-PILOT	STUDENT
ALL MODELS			127.3	CV LANDINGS DAY/NIGHT			Ø
ALL MODELS IN LAST 12 MOS.			127.3	FCLP LANDINGS DAY/NIGHT			Ø
ALL MODELS IN LAST 3 MOS.			55.1	INSTRUMENT HOURS, LAST 3 MONTHS			20.9
ALL SERIES THIS MODEL			89.6	NIGHT HOURS, LAST 3 MOS.			4.0
ALL SERIES THIS MODEL, LAST 12 MONTHS			89.6	(jet accidents only) TOTAL JET PILOT HOURS			- -
ALL SERIES THIS MODEL, LAST 3 MONTHS			55.1	DATE LAST FLIGHT, ALL SERIES THIS MODEL			4-25-58
				DURATION LAST FLIGHT, ALL SERIES THIS MODEL			0.3

13. ALL PERSONNEL

	NAME (last, first and middle initial)	RANK RATE	FILE SERVICE NO.	ORG. TO WHICH ATTACHED	INJURY CODE	BILLET	POSITION
1.	(b) (6) [redacted]	N/C	(b) (6) [redacted]	BTG-3S Whiting Field	D	Stud.	F/C
2.							
3.							
4.							
5.							

(If additional space is necessary, attach additional sheet(s))

OPNAV FORM 3750-1 (REV. 11-55)
PAGE 2

AIRCRAFT ACCIDENT REPORT

OPNAV REPORT 3750-1

SECTION C. — SECTION D. — SECTION E. — SECTION A – AIRCRAFT AND ENGINE DATA

1. CEILING	2. VISIBILITY	3. WIND DIRECTION AND VELOCITY	4. TEMPERATURE	OUTSIDE AIR	RUNWAY	5. DEW POINT	6. ALTIMETER SETTINGS
2500 SCAT	12 Mi.	135 Deg. 3 Kts.		80	NA	65 Deg.F.	30.08

7. OTHER WEATHER CONDITIONS (winds aloft, icing levels, state of sea, etc., if pertinent to accident)

Not pertinent

ITEM	P	S	ITEM	P	S	ITEM	P	S
PILOT ERROR	X		LANDING SIGNAL OFFICER ERROR			MATERIAL FAILURE OR MALFUNCTION		X
CREW ERROR			OTHER PERSONNEL ERROR, Specify			MATERIAL INADEQUACY		
SUPERVISORY PERSONNEL ERROR			ADMINISTRATIVE ERROR			ROLLING AND PITCHING DECK/ROUGH SEAS		
MAINTENANCE PERSONNEL ERROR			AIRPORT OR CARRIER FACILITIES			UNDETERMINED		
SERVICING PERSONNEL ERROR			WEATHER			OTHER, Specify		

FOR ACCIDENTS ABOARD DEPLOYED CARRIERS (Complete following Section on Pilot)

1. DATE DEPLOYED	2. DAY-HOURS/LANDINGS LOGGED SINCE DEPLOYED	3. DAY-HOURS/LANDINGS LOGGED LAST 30 DAYS
NA	NA	NA
4. INSTRUMENT HRS. LOGGED SINCE DEPLOYMENT	**5. NIGHT-HOURS/LANDINGS LOGGED SINCE DEPLOYED**	**6. NIGHT-HOURS/LANDINGS LOGGED LAST 30 DAYS**
NA	NA	NA

PART II – MAINTENANCE, MATERIAL AND FACILITIES DATA

	DATE OF	SERVICE TOUR	MONTHS IN THIS TOUR	TOTAL NO. OF OVERHAULS	FLIGHT HRS. SINCE LAST OVERHAUL	FLIGHT HRS. SINCE ACCEPTANCE	TYPE CHECK LAST PERFORMED	FLIGHT HRS. SINCE LAST CHECK	NO. OF DAYS SINCE LAST CHECK
1. AIRCRAFT HISTORY	Acceptance by Navy. 5-26-55	1	22	1 Minor	518.1	1417.7	120 Hr. 2nd. Int.	0.8	28
		ENGINE MODEL	SERIAL NO. OF ENGINE						
2. ENGINE HISTORY NO. 1	2-23-56	R1820-86	BL 520765	1 Minor	518.1	1604.5	120 Hr. 2nd Int.	0.8	28
NO. 2									
NO. 3									
NO. 4									

3. GENERAL

a. DID FIRE OCCUR: ☐ BEFORE ACCIDENT ☐ AFTER ACCIDENT ☒ DID NOT OCCUR

b. DID EXPLOSION OCCUR IN FLIGHT? ☐ YES ☒ NO

C. CHECK IF APPLICABLE ☐ AMP FUR SERIAL

D. HAS DIR BEEN REQUESTED? ☒ YES ☐ NO

E. FAILED COMPONENTS INVOLVED: Undetermined

4. A/C MAINT. AND ENG. FACTORS

CHECK BELOW ITEMS PRESENT IN THIS ACCIDENT

a. ☐ AIRCRAFT DESIGN
b. ☐ AIRCRAFT EQUIPMENT
c. ☒ MAINTENANCE
d. ☐ UNDETERMINED
e. ☐ TECHNICAL INSTRUCTION
f. ☐ OTHER, Specify
g. ☐ SURFACE FACILITIES
h. ☐ HUMAN ENGINEERING (e.g. cockpit configurations)

6

5. MISCELLANEOUS DATA

A. ALTITUDE AT MALFUNCTION	B. AIR SPEED (kts)	C. OPERATING TEMPERATURE	D. WEIGHT OF AIRCRAFT	E. C.G.(% MAC)	F. KIND OF FUEL	G. FUEL PRESSURE
0	50	Normal	8,000.	NA	100/130	Normal

H. EVIDENCE OF FUEL CONTAMINATION: Fuel being tested.

I. CAUSE OF ENGINE FAILURE OR FLAMEOUT: NA

J. FUEL CONTROL REGULATOR/CARBURETOR (List Stock and Ser. nos., give time since new or overhauled): 798278 PD12K18 /520.9 hours

K. EXTERNAL STORES ABOARD A/C: None

(If additional space is necessary, attach additional sheet(s))

AIRCRAFT ACCIDENT REPORT

PART II – MAINTENANCE, MATERIAL AND FACILITIES DATA (Cont'd)

SECTION B – FACILITIES DATA

a. ☐ CLEARANCE AUTHORITY	h. ☐ RUNWAY	o. ☐ EMERGENCY ARRESTING GEAR (Runway)
b. ☐ FLIGHT PLANNING INFORMATION SOURCE	i. ☐ WATER LANDING AREA	p. ☐ AIRCRAFT SERVICING, HANDLING & DIRECTING (Field or Ship)
c. ☐ LANDING AIDS (GCA, CCA, ILS, etc.)	j. ☐ APPROACH ZONE	q. ☐ CRASH AND RESCUE
d. ☐ TRAFFIC CONTROL TOWER (Field or Ship)	k. ☒ END ZONE	r. ☐ SEARCH AND RESCUE
e. ☐ APPROACH AND ENROUTE AIDS TO NAVIGATION	l. ☐ SHOULDERS	s. ☐ CATAPULT
f. ☐ RUNWAY WATCH	m. ☐ TAXIWAY	t. ☐ ARRESTING GEAR (Carrier)
g. ☐ LANDING SIGNAL OFFICER	n. ☐ PARKING AREA	u. ☐ BARRIER OR BARRICADE (Field or Ship)
w. ☐ OTHER, Specify		v. ☐ FLIGHT DECK

a. EQUIPMENT INVOLVED: ☐ CATAPULT ☐ ARRESTING GEAR	B. PRESSURE SETTINGS	C. WIND OVER DECK	D. RELATIVE HEADWIND	E. APPROACH SPEED (SPN-12 READING)	
F. MARK NUMBER	G. MODEL NO.	H. LOCATION ON SHIP	I. LAUNCHING BRIDLE AND CONFIGURATION USED		
THIS SECTION DOES NOT APPLY					

J. CATAPULT/ARRESTING GEAR BULLETINS OR NOMOGRAMS USED

K. THIS PORTION SHALL BE COMPLETED WHENEVER (1) A MAJOR AIRCRAFT ACCIDENT INVOLVES ARRESTING GEAR, BARRIER AND/OR BARRICADE EQUIPMENT, OR (2) AN AIRCRAFT ACCIDENT INVOLVES MALFUNCTIONING OF ARRESTING GEAR, BARRIER AND/OR BARRICADE EQUIPMENT. MINOR ACCIDENTS OR ROUTINE DAMAGE TO CABLES, WELDINGS AND OTHER EXPENDABLE COMPONENTS NEED NOT BE REPORTED.

ENGAGED	DECK RUNOUT (FT.)	RAM TRAVEL (IN.)	CONTROL VALVE SETTINGS: CONSTANT PRESSURE DOME (P.S.I.)	CONSTANT PRESSURE RATIO	CONSTANT RUNOUT (WT. LBS.)	ACCUMULATOR PRESSURE (PSI)	COMMENTS (for cable failure specify number of landings and months in service)
DECK PENDANT							
DECK PENDANT			THIS SECTION DOES NOT APPLY				
BARRIER							
BARRIER							
BARRICADE							

PART	ITEM	PART III – REMARKS (continue on separate pages if necessary)
		No damage to government and/or private property.
		Distribution. Direct copies to:
		NAVAVSAFCEN, NORVA
		1cc BUAER (AER-512)
		1cc BAR, NAA, Inc., Columbus, O.
		1cc BAR, Curtiss-Wright Corp., Wood-Ridge, N.J.
		1cc Naval Liaison Officer, DPSR, Norton AFB, San Bernardino, Calif.
		1cc NAAS, Barin Field
		1cc BSG, NAAS Corry

7

(b) (6)

[redacted]

ADDENDUM to Section B AAR From 3750-1 NAAS Whiting Field Aircraft Accident Report No. 6-58

All operational flight simulator and pilot trainer time:

Item	Pilot	Student
This model (T-28 NAVBIT)	- -	21.0 Hrs.
Last 12 months		21.0 Hrs.
Last 3 months		0.0

NAS Whiting Field Aircraft Accident Report No.6-58

Part V - The Accident.

On 30 April 1958 at 1242Z NavCad (b) (6) [redacted] aborted a takeoff from NAS Whiting Field, South Field. He was flying a T-28B, Bureau No. 138252, and was commencing an authorized training syllabus F-11 and F-12 formation flight.

At about 1200Z this date, NavCad (b) (6) [redacted] was briefed for the flight. After the briefing, he manned his aircraft, taxied out to the runway, and parked beside his instructor's aircraft for turn-up. The turn-up was normal except that the aircraft's brakes would not hold at thirty inches manifold pressure.

NavCad (b) (6) [redacted] took off at 1242Z as the No. 2 man in a flight of five. Just after the aircraft became airborne, NavCad (b) (6) [redacted] felt that the aircraft was experiencing power loss so he retarded the throttle to abort the takeoff.

The aircraft touched down 1264 feet from the end of the runway, flaps up, gear down at an estimated airspeed of ninety knots. The aircraft continued down the runway veering slightly to the right and overran the end zone. It continued over the grass, jumped a small ditch and hit an embankment on the other side at an estimated speed of fifty knots.

The nose gear collapsed on this embankment; the aircraft flipped over and came to rest on its back 280 feet from the end of the runway. The pilot's injuries were minor. The aircraft sustained strike damage.

Part VI - Damage to Aircraft.

BUNO 138252 sustained strike (Life) damage as a result of this accident. No damage was caused to the aircraft until after the aircraft struck an erosion ditch and embankment 150 feet beyond the end of the runway. The nose gear also buckled and port gear trunnion fractured on impact. The nose gear dug into the ground for eight feet in length before the aircraft left the bank on the opposite side. The prop bit three times into the face of the bank.

The aircraft hurtled through the air for thirty-five feet before striking the ground on the nose, port wing low. The aircraft skidded on its nose and port wing for thirty-three feet buckling the engine mounts and severing the propeller from the nose section. The port wing tip and outer port wing panel were moderately buckled. The aircraft's nose dug into the ground and the aircraft flipped over landing upon its back buckling the fuselage, crushing the windshield and canopy crushing and severing vertical stabilizer and rudder, and buckling both wings.

Part VI - Damage to Aircraft. (Continued)

The cowling was torn off on impact on the lower and starboard side. The center cowl and port cowl was crushed but remained on the engine.

The airframe was sent to Overhaul and Repair, NAS Pensacola for salvage.

The engine received sudden stoppage at idle RPM, and was sent to O&R, NAS, Pensacola, for disassembly and inspection.

Part VII - The Investigation.

The following facts were revealed in the investigation.

A. NavCad [redacted] (b) (6) in T28B, BUNO 138252, was on an authorized F11 and F12 Formation Flight in company with four other aircraft.

B. At approximately 1200S NavCad [redacted] (b) (6) and his flight were briefed by ENS [redacted] (b) (6) who was assigned as chase pilot for this flight. Following the briefing the pilots departed for their aircraft.

C. 1. Preflight Inspection:

According to N/C [redacted] (b) (6) statement and interview, a thorough preflight and aircraft inspection was performed which included inspecting past discrepancy sheets which were available at the yellow sheet box. (See Enclosure 1) No discrepancies were noted. On the inspection of the aircraft brake assembly, the brake discs rims were rusted on both main wheels; the brake pucks had sufficient puck on both wheels to allow good braking; however, the right starboard brake had a black oily or greasy substance around the pucks. No other pertinent items were mentioned.

2. Starting:

Upon manning the aircraft and properly seating himself in the front cockpit, the pre-starting check-off list was performed and aircraft started. A good start was obtained. The engine instruments were noted to be normal and cylinder head temperature rising.

3. Taxi:

Following completion of the pre-taxi check-off list and radio check, the chocks were pulled. The standard procedure of checking the brakes on departing the chocks was initiated and the brakes were effective. N/C [redacted] (b) (6) then continued his taxi to the engine run-up area for runway No. 9.

10

Part VII - The Investigation. (Continued)

4. Runup:

N/C (b) (6) parked next to his chase instructor, ENS (b) (6) and performed his engine runup. The proper engine runup procedures were used except for the following:

a. Parking brakes are not used as SOP for engine runups. Foot shall remain on brakes to maintain brake pressure.

During the engine runup, N/C (b) (6) observed the following irregularities:

a. Propeller control had moved aft from low pitch setting on taxi. He adjusted the friction knob.

b. The aircraft brakes crept on three occasions during runup near thirty inch manifold pressure setting. The first two times the brakes crept were with the parking brake set. The third time was with N/C (b) (6) exerting physical pressure until the completion of the runup.

c. N/C (b) (6) called the instructor on Channel 14 and told him that his brakes were creeping. The instructor, ENS (b) (6) asked (b) (6) if his magneto check was satisfactory and when told that it was did not say anything but shrugged his shoulders.

During the runup the engine checked out satisfactorily in all respects.

(1)	Propeller check at 1500 RPM	200 RPM drop
(2)	Supercharger check	Engaged, then disengaged with 2" MP drop
(3)	Rotor check	2200 RPM
(4)	Magneto check	40 and 50 RPM drop
(5)	Idle mixture check	No rise in RPM
(6)	Carburetor mixture check (1800 RPM)	Very slight rise 5 RPM

Following runup the engine was idled at 1200 RPM and takeoff check list completed with exception of the canopy "closed" and engine cowl flaps "trailed."

11

5. Take-Off:

There were no delays in the flight and at approximately 1240s N/C (b) (6) flight was cleared for takeoff on runway No. 9 by the Tower.

Part VII - The Investigation. (Continued)

N/C (b) (6) completed his take-off check-off list "closing" the canopy and "trailing" the engine cowl flaps. When the leader commenced his take-off roll, N/C (b) (6) held the brakes and applied thirty inches MP; the aircraft brakes crept. Engine instruments were normal. The brakes were released and forty-eight inches MP added. Prior to becoming airborne, the aircraft "bounced around." Fifty inches of MP were added and the aircraft became airborne. N/C (b) (6) "felt the aircraft losing power." The engine was running rough and not climbing.

6. Rolending:

N/C (b) (6) decided to abort the takeoff. He closed the throttle and pumped the brakes twice as he flared out. The aircraft would not settle, so the nose was lowered and another flare to touchdown made.

D. Preliminary Investigation of the Wreckage.

1. Aircraft's path.

The Aircraft touched down on runway 9 with the port gear first leaving a skid mark seventeen feet long. This touch down was 1464 feet from the end of the runway. Twenty-two feet later the starboard gear touched down leaving a twelve foot skid mark. The nose gear touched down forty-two feet farther leaving a six foot mark. The touch down was accomplished with the starboard gear landing on the left center line. The wheel marks started a gentle arc to the right. One hundred nine feet after initial touchdown, the starboard wheel left a skid mark twelve feet in length. No distinct braking skid marks were found on the port wheel track. All three wheels left marks which extended to the end of the runway and through the overrun until they reached a ditch 150 feet beyond the end of the runway. The starboard wheel mark was the heaviest of the three, but was still light. The port wheel mark was faint but distinct. The nose wheel mark was the lightest of the three but also distinct. On the 150 feet grass covered overrun, the three wheels left marks of about the same depression. One hundred fifty feet from the end of the runway is a shallow ditch which is twenty-one feet wide. (See Enclosure 5.) The main mounts left the ground in the ditch and touched the embankment eight and one-half feet on the other side. The port gear collapsed at this point. The nose wheel left the ground and hit the embankment on the other side where the strut collapsed at the oleo. The strut plowed a gouge through the top of the embankment eight feet long.

12

Part VII - The Investigation. (Continued)

When the aircraft hit the embankment and the nose gear and port strut collapsed, it started to nose up. There were no marks on the ground from this point until twenty-one feet later where there was a flat propeller slash. Fourteen feet farther along there was the narrow mark of the propeller dome which ran for eight and one-half feet into a shallow scope-out two and one-half feet wide and thirty-three feet long which was made by the engine and cowling. Three feet down and three feet to the right of the propeller dome mark was a very flat propeller slash. There were no ground marks for eighteen feet following the engine scope. Eighteen feet from the engine scope was a hole left by the front windshield bow. The aircraft came to rest inverted after having slid inverted for eight and one-half feet with the tail pointing in the direction of movement.

2. Propeller Marks.

Three propeller marks were found in the embankment by the ditch. (See Enclosure 5.) The second was two feet and two inches from the first and the third was three feet from the second. At an idling speed of 800 RPM's versus the distance between the first two propeller marks, the forward speed of the aircraft at the embankment was calculated to be fifty-two knots.

3. Aircraft Configuration.

The aircraft was in a gear down, flaps up configuration. The cowl flaps were open one-fourth. The canopy was eight inches from being closed and the handle was in the "full close" position. It could not be determined, but it is believed that the canopy was in the "closed" position when the aircraft overturned. The pilot did not remember. Two witnesses say that it was closed when it struck the ditch.

4. Controls and Instruments.

a. Inspection of the forward cockpit revealed the following control settings.

(1)	Throttle	Full open
(2)	Propeller	Full increase
(3)	Mixture	Normal
(4)	Friction knob	Moderately tight
(5)	Blower	Low
(6)	Flaps	Up

Part VII - The Investigation. (Continued)

(7)	Gear handle	Down
(8)	Fuel selector	On
(9)	Alternate air	Direct
(10)	Trim tabs: Elevator	4 degrees up
	Aileron	0 degrees
	Rudder	1 degree left
(11)	Speed brake	Up
(12)	Cowl flaps	¼ open
(13)	Ignition switch	Both
(14)	Battery switch	Batt-Gen.
(15)	Shoulder harness inertia reel	Unlocked
(16)	U.H.F.	On Channel 10
(17)	Canopy control	Full close
(18)	Circuit breakers	Port landing light
(19)	Inverter	No. 1
(20)	Control shift	Front

Similar controls in the rear cockpit were at the same settings as those in the forward cockpit.

b. Instruments.

The forward accelerometer read plus 9.1 and minus 4.5.

Because of the limited damage to the cockpits and the relatively small forward G force sustained, the instruments were undamaged and indicated the same as a normal shut down aircraft. Both clocks were still running and indicated the correct time.

5. Trim Tabs.

The elevator trim tabs positions were determined to be right tab up and left tab down.

It was determined that the tabs reversed after impact. The tab cables severed on impact and rotated the cable drums each drum being rotated separately. The trim tab systems were inspected and it was determined that all were properly rigged. 14

R. Engine.

Prior to DIR certain limited investigations were conducted by NAS Whiting Field Maintenance Department. Impact damage to the engine was moderate. Due to the extreme impact angle the complete nose section was broken off exposing the planetary gears which remained with the propeller. Push rods and exhaust stacks were bent.

Part VII - The Investigation. (Continued)

The carburetor inlet strainer was removed and inspected for foreign matter. It was found to be clean and free of foreign matter. The main oil strainer was removed and inspected. It was found to contain large deposits of carbon and oil sludge. Fuel and oil samples were drawn from the engine for analysis. The inside of the cylinders were Bore Scoped for condition and found to be normal.

The magnetic sump plugs were examined and no metal was found.

The engine was sent to Overhaul and Repair N.A.S Pensacola for DIR.

The spark plugs were bomb tested at 155 pounds psi and then installed in another engine for engine analyzer confirmation. The results of those tests were as follows:

Plug No.	Bomb Test	Analyzer
Front		
1	No test - oil soaked	Fouled
2	Quench out (125 psi)	Fouled
3	Carbon tracking	Fouled
4	Carbon tracking	Fouled
5	Bent - no test	No test
6	Carbon tracking	Fouled
7	Bent plug - no test	No test
8	Quench out (135 psi)	Fouled
9	Oil soaked - no test	O.K.
Rear		
1	Oil soaked - no test	Fouled
2	Carbon tracking	O.K.
3	Carbon tracking	Fouled
4	Quench out (125 psi)	Fouled
5	Unable to remove due to impact damage	
6	Unable to remove due to impact damage	
7	Unable to remove due to impact damage	
8	Carbon tracking	O.K.
9	Breaking down - shorting out	O.K.

Under magnifying glass it was determined that all plugs were extremely fouled with carbon deposits between the electrodes and deep within the plug body. During investigation of past history it was noted that this

Part VII - The Investigation. (Continued)

aircraft had not flown for twenty-seven days. Every third day the aircraft was turned up to preclude pre-oiling. The Board could not determine that the turn-ups (nine of them) were always adequate to do anything toward engine conditioning other than circulate the oil. It is presumed that the carbon deposits were an accumulation of deposits left on the plugs at each turn-up. The plugs were obviously operating except in the case of cylinders No. 1, 3, and 4 wherein there was a double failure at high takeoff pressure. A definite power loss would be the result. Some engine roughness undoubtedly would result also from improper burning of fuel-air mixtures in nearly all other cylinders.

The main oil strainer was investigated and found to be so badly restricted by what appeared to be carbon and sludge that it is estimated that three-fourths of the oil should have been by-passing this strainer. This contamination was without doubt also caused by inadequate turn-ups. It is believed by the Board that this dirty strainer has no bearing on the accident but is good confirmation of aircraft condition after being idle for twenty-seven days.

F. Brake Inspection.

At the scene of the accident the brakes were inspected and found to be hot. The brake assembly was visually inspected and was intact. The brake puck clearances were within tolerances, and the brake discs showed normal wear with a coating of rust on the outer rim of both discs.

The brake pucks were removed and inspected and were found to have considerable deposits on them. The deposits appeared to be accumulated carbon deposits such as would result from greases. Samples of these deposits were sent to the N S Pensacola O&R laboratory for analysis.

The right brake pucks appeared to have undergone more intense heat than the left.

Inspection of maintenance records revealed that the port wheel brake pucks were changed on 1 April 1958 just before the aircraft went into check.

G. 1. Witnesses:

Several witnesses observed the aircraft abort the take-off and overrun the runway. The pilot's statements were all consistent and substantiated the evidence found at the scene. The following enumerates the information gathered from the pilot witnesses. (Enclosures 2a - 2j.)

Part VII - The Investigation. (Continued)

a. The aircraft showed little outward sign of breaking except at the end of the runway.

b. The speed of the aircraft over the end of the runway was somewhere between forty and sixty knots.

c. The aircraft hit the ditch and embankment with the landing gear jumping the ditch. The aircraft nosed up at this point and flipped over on its back after riding for a brief moment on its nose.

d. It took the crash truck from four and a half to five minutes to reach the crash after the Tower was notified that an aircraft had run off the end of the runway.

e. The crash truck proceeded to the hub then down runway 4 before turning over to the east end of runway 9.

f. After the crash was reported, the tower operator asked if the aircraft was a dual or a solo, and the side number of the aircraft.

Further interview of pilot witnesses indicate that it had to be pointed out to the tower operator that a serious crash had occurred and immediate action was necessary.

2. The time lapse between the occurrence of the accident and the arrival of the crash truck at the scene of the accident was a minimum of four and one-half minutes and probably closer to five minutes. When the Tower was cognizant of the accident the crash alarm was sounded and the standby crash crew was instructed by the Tower personnel to proceed to the "takeoff" end of runway nine. The standby crash crew proceeded to the hub and started to head west down runway 9-27 when the Tower called them and instructed them to proceed down runway 27. At this point the crash truck stopped for about thirty seconds and displayed confusion as to which way to go. When the crash truck determined in which direction to proceed they started east down runway 9-27 and then turned northeast down runway 4-22 upon sighting an aircraft with the cut engine on the perimeter taxiway between runways 4 and 27. When the truck arrived at the parked aircraft, the pilot of this aircraft waved it on and pointed in the direction of the accident. Upon arriving at the end of the runway, the crash crew sighted the pilot and left a man with him to render first aid. The crash truck proceeded beyond the end of the runway where they first sighted the accident which was hidden by the embankment off the east end of runway 9-27.

17

Part VII - The Investigation. (Continued)

The duty crash truck, set up at the west end of runway 9-27, first realized something amiss when pilots in the adjacent turn-up area waved and pointed to the opposite side of the field. The crash crew then observed the standby truck heading for the hub and departed their position and proceeded east on runway 9-27. They called the Tower requesting information as to whether there was a crash. The Tower's reply was garbled. The duty crash truck followed about 1500 feet behind the standby truck to the scene.

H. Medical Aspects:

The Medical Officer's Report (Enclosure 6) states that no sociological, psychological, physiological or human engineering factors could be elicited.

I. Pilot's Equipment:

N/C (b) (6) was held securely in the cockpit by tightly locked shoulder harness and seat belt. His equipment proved very effective. His hard hat which he was wearing was punctured by a piece of plexiglass from the forward canopy frame allowing his scalp to receive only a minor cut. The goggles protected his eyes from dirt, plexiglass and oil which was running from the oil tank into the cockpit. The oxygen equipment and parachute were not used.

J. Pilot's history:

A review of N/C (b) (6) flight jacket revealed that he was an average student with an overall flight grade of 2.55. He has had one down, which was at NAS Saufley Field.

T-7 Pre-solo, T-34 Course Rules.

N/C (b) (6) ground school grades were average, although N/C (b) (6) had failed three tests in ground school which were retaken and passed. They were:

IR Navigation
Communication (Flag
Radio Instruments Flight Procedures.

N/C (b) (6) has not had any previous accidents or flight violations.

Part VIII - The Analysis.

A. 1. Pilot's Reaction.

Sociological, psychological or physiological factors were determined not to be a consideration to this accident. The training procedures and pre-flight briefing were also determined not to be contributing factors so the events leading to the accident from pilot consideration started at the turn-up area.

It was during turn-up that the pilot discovered that his brakes would not hold the aircraft at thirty inches manifold pressure. At this time he should have downed the aircraft, cut the engine, and had the aircraft towed in to the line, or at least taxied as far as possible in the uncongested area before cutting the engine. It is felt by the Board that when the instructor became aware that N/C (b) (6) [redacted] brakes were creeping, he should have advised (b) (6) [redacted] to down his aircraft. The reluctance of a pilot to down his aircraft and delay an entire flight is understood, but there are minimum standards that an aircraft should meet before a flight and when the aircraft falls below these standards, it should be downed without fail.

The remainder of the turn-up was normal and the aircraft's power plant checked out satisfactory.

At the takeoff position on the runway thirty inches of M.P. was applied for final instrument check and the pilot was not able to keep the aircraft from moving with the use of brakes.

On takeoff the pilot determined just after becoming airborne that the engine was running rough and it was then that the decision was made to abort the takeoff. The pilot had to step the aircraft down to the runway for the touchdown indicating that the landing was made at a slightly fast airspeed. The skid marks and run out marks on the runway show clearly that heavy braking was used only once right after touchdown. The reason for this was two-fold.

a. Maximum brakes were not available as determined from the pilot's statement that the brakes would not hold at thirty inches Hg.

b. Brakes available were not used. The pilot's interview and statement indicates that the brakes were pumped twice before touchdown then after touchdown the brakes were pumped twice before steady braking was applied. From the pilot interview it was determined that he did not realize the situation he was in until

Part VIII - The Analysis. (Continued)

the end of the runway was approached. It was here that he applied steady braking. After the crash the brake discs and pucks showed evidence of much heat. The touchdown was effected 1465 feet from the end of the runway, slightly fast (estimated 90-100 knots) with flaps up. The wind was calm. The T28B Handbook stopping distance graph shows that the stopping distance of a T28B at half flaps is 1400 feet on a no wind standard day with a 80 knot touchdown airspeed. This condition is set with hard braking and no power. Comparing the two aircraft configurations, speed, and power settings, it can be seen that 1,465 feet would not be enough runway to have effected a complete stop using maximum braking.

Although a complete stop was unlikely the aircraft could have been slowed down to a ground speed considerably less than the fifty knots at which it struck the embankment if maximum braking available was applied from touchdown to rest.

The battery and fuel selector were left on throughout the accident events. The position that the aircraft came to rest is probably the reason that it did not burn. It can be seen that it is highly desirable to turn off the battery switch and fuel selector and open the canopy before an accident occurs. A pilot should make every effort to do this when a crash is inevitable.

c. NavCad (b) (6) [redacted] was extremely fortunate to have survived the accident with only minor injuries. The effectiveness of the seat belt and shoulder harness used properly were emphasized by this accident. Aside from the shoulder harness it is considered also that the H-4 helmet that the pilot was wearing probably saved his life. The helmet had a hole punctured in the back of it by a large jagged edge of canopy glass. The pilot received only a minor cut from this blow.

B. Engine.

The preliminary investigation conducted by the Maintenance Department indicated that the power loss experienced by the aircraft at takeoff power was highly likely. Most of the spark plugs checked out unsatisfactory by the engine analyzer and bomb test and all of the plugs were fouled with carbon deposits.

The aircraft had not flown for twenty-seven days prior to the accident being AOG for exhaust stack clamps. The aircraft was turned up every

Part VIII - The Analysis. (Continued)

three days to preclude pre-oiling and it is considered by the Board that these turn-ups were inadequate.

The fouled oil strainer found on the aircraft also points to inadequate periodic turn-ups of the downed aircraft.

C. The significant points from the position of the controls after impact were that the canopy lever was closed, the battery switch and fuel selector were on. (Above) The throttle control was forward and the mixture was normal, but it is felt that the controls were thrown into these positions after the fact.

D. Overrun.

The overrun off the east end of runway 9 is highly inadequate and falls far short of the standards set by BuAer Notice 1132 of 10 April 1958 (Subject: End zones, Maintenance of) Considering all other factors of the accident as they happened, it is likely that this accident would have been a minor one if the overrun had been adequate.

E. Tower Control and Crash Crew:

The time lapse between the accident and the crash trucks' arrival at the scene was four and one-half minutes minimum and probably closer to five minutes. This time interval for a crash within field boundaries was entirely too long and because of the nature of this accident could have resulted in the death of the pilot.

The reason for the long delay appeared to be due to confusion in communications between the control tower and the crash trucks, and delay of the tower operator to treat the crash as one of other than a minor nature. It is imperative that standard communications between the tower operators and crash crews be learned and used in all cases. It is equally imperative that the tower operators treat every unusual occurrence involving aircraft with the same seriousness and procedure until the situation is alleviated.

Part IX - Conclusions and Recommendations.

Conclusions:

The Board concludes that the primary cause of the accident was pilot error in that the pilot should have downed the aircraft after realizing that the brakes were marginal.

Part IX - Conclusions and Recommendations.

There are several contributing factors to the accident.

1. The pilot failed to use maximum braking available after touchdown; the pilot pumped the brakes twice before applying steady braking instead of applying maximum braking right after landing to stop in the short distance (1465 feet) left to him.

2. Supervisory error contributed to the accident in that the instructor chasing the flight did not advise the student to down his aircraft after the instructor was cognizant that the student's brakes were creeping.

3. (a) Material failure contributed to the accident. A majority of the spark plugs were unsatisfactory, probably as a result of inadequate turn-ups over a twenty-seven day period, and would not function correctly under take-off power.

   (b) Excessive grease was observed around the brake pucks on the right brakes before the flight. On inspection the pucks showed deposits of carbon burned into the pucks which probably resulted from excess adhesive substance used to install the pucks.

4. Inadequate runway overrun was a contributing factor. The overrun off of the east end of runway 9-27 is far below the standard cited in BuAer Notice 1132 of 10 April 1958, (Subject: End zones, Maintenance of).

The Board recommends that:

1. It be re-emphasized to all pilots not to accept an aircraft with marginal or faulty brakes. It is far better to delay a five plane flight than to accept an aircraft that is a potential accident. An aircraft with marginal brakes should not be taxied in any close quarters, but should be shut down and towed.

2. All solo pilots be reminded that it is their responsibility to determine if an aircraft should be downed. They can seek advice from more qualified personnel, but the final decision is theirs.

3. It be emphasized to all pilots that if a crash is inevitable, it is imperative that every effort be made to open the canopy and turn off the battery switch and fuel selector before impact.

4. When an aircraft is turned up for engine conditioning, it be given a completed pre-flight turn-up to include propeller check, power check, supercharger check, magneto check, and mixture check and that the aircraft be shut down using the proper scavenging procedure.

Part IX - Conclusions and Recommendations.

5. That maintenance personnel while installing brake puck take exceptional care not to use an excessive amount of adhesive substance.

6. That a standard communication system between the tower operators and the crash crew be learned and used. This system should include a means to provide a speedy exchange of information as to the location of any geographic point on and around the field.

7. All tower operators be continually alert as to where every assigned aircraft is around the field and what it is doing. Particular attention should be given to those aircraft taking off and landing.

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (5), (b) (6)

(b) (6)

MEDICAL OFFICERS REPORT OF AIRCRAFT ACCIDENTS/INCIDENTS AND GROUND ACCIDENTS

OPNAV FORM-3750-8 (REV. 2-54)
(SUPERSEDES OPNAV FORM-3750-7)

0258

OPNAV REPORT-3750-7

GENERAL INSTRUCTIONS

1. This report shall be filed in the event of an aircraft accident/incident which involves one or more of the following:

   Death
   Injury,
   Bail-out or Ejection (attempted or successful)
   Wherever physiological or psychological factors are involved
   Aircraft Ground Accidents resulting in serious injury

   Ditching
   Water Crash

2. Completion of the form shall be the responsibility of the flight surgeon
3. For type accident and damage code refer to OPNAV INSTRUCTION 3750.6A
4. This form shall be prepared in quadruplicate. One copy shall be turned over to the Aircraft Accident Board (or the Survival and Intelligence Officer in the case of combat incidents), and the original shall be air mailed (regular mail within 250 miles of Washington, D.C.) direct to Chief of Naval Operations (OP-57) Navy Department, Washington 25, D.C. within 4 working days following the accident. The third copy shall be mailed direct to Safety Equipment Branch, BUAER, Navy Department, Washington 25, D.C. The fourth copy shall be forwarded direct via air mail (regular mail within 250 miles of Norfolk, Va.) to the U.S. Naval Aviation Safety Activity, Naval Air Station, Norfolk 11, Virginia. Where more than one aircraft is involved, separate forms must be completed for each aircraft wherein one or more of the requirements in paragraph 1. above are applicable. (Additional copies may be prepared for use of squadron flight surgeons and other interested individuals)

1. FROM (Ship or station address) NAAS WHITING FIELD, MILTON, FLA.
2. SERIAL NO. 6-58
3. ACCIDENT OCCURRED (Geographic location) Overshoot end of runway #9 South Whiting Field
4. TIME (Local) 1242
5. DATE 1-30-58

6. PLANE COVERED BY THIS REPORT — MODEL T-28B — BU. NO. 136252 — NO. OCCUPANTS 1 — UNIT OPERATING AIRCRAFT ATG-38 Whiting Field — TYPE ACCIDENT F-1 — DAMAGE A
7. OTHER PLANE (if involved) — MODEL — BU. NO. — NO. OCCUPANTS — UNIT OPERATING AIRCRAFT — DAMAGE
8. NAME OF PILOT IN CONTROL OF AIRCRAFT AT TIME OF ACCIDENT/INCIDENT (last, first, middle) (b) (6) [redacted] — UNIT PILOT ATTACHED TO ATG-38 Whiting Field

SURGEONS CHECK LIST: ALL PARTS OF FORM COMPLETED ☐ SURVIVORS NARRATIVES ☐ PHOTOS AS NEEDED ☐ RECOMMENDATIONS ☐ COPIES FURNISHED ☐

10. REPORT FILED BY (b) (6) [redacted] II, MC USN — SIGNATURE — DATE 5-6-58
11. T.J. HAMILTON, CAPT. MC USN — SIGNATURE — DATE MAY 7 1958
12. ☒ AIRCRAFT ACCIDENT ☐ AIRCRAFT INCIDENT ☐ COMBAT INCIDENT ☐ GROUND ACCIDENT

13. ACCIDENT DESCRIPTION

INCLUDE HERE A PARAGRAPH GIVING A BRIEF BUT FACTUAL ACCOUNT DESCRIBING THE ACCIDENT/INCIDENT. INCLUDE SUCH CAUSES AS KNOWN, ESTIMATES OF "G" FORCES, ANGLES OF IMPACT, SPEED ON IMPACT, ATTITUDE ON IMPACT, ETC. ATTACH PHOTOGRAPHS WHEN PERTINENT.

Student was on a F-11 solo four plane formation hop from South Whiting Field. Pre-flight check and engine run-up were normal except that the plane tended to creep on the mag check. On take-off the pilot noted that there was an exceptionally long roll out and that " the plane took a long time to become airborne". Immediately after becoming airborne the pilot noted that the engine was running roughly and that the plane would not hold altitude, "as if I were losing all my power". He immediately decided to abort the take-off and nosed the plane over to the runway. He touched down 1465 feet from the end of the runway and immediately began hard braking. Estimated speed on touchdown was approximately 70 knots. He was unable to stop the aircraft even after "Standing on the brakes as hard as I could" and the plane ran off the end of the runway, striking a mound of dirt in the overshoot area. After striking the mound of dirt the nose wheel collapsed and the prop was sheared from the engine. The aircraft then flipped over and came to rest inverted, heading in the opposite direction from takeoff. The pilot loosened shoulder harness and safety belt, and, after digging a hole at the side of the cockpit, crawled away from the wreckage. There was no fire or explosion.

41

14. PILOT FACTORS (Check pertinent pilot factors listed below)

	PILOT	CO-PILOT		PILOT	CO-PILOT
IN CONTROL AT TIME OF ACCIDENT/INCIDENT	X		HYPOXIA SUSPECTED	no	
AMOUNT OF FLIGHT TIME IN LAST 24 HOURS	none		CARBON MONOXIDE POISONING SUSPECTED	no	
NUMBER OF FLIGHTS IN LAST 24 HOURS	0		FAULTY VISION	no	
NUMBER HOURS DUTY IN LAST 24 HOURS	0		AEROEMBOLISM	no	
HOURS SINCE LAST FULL MEAL	1.2		BLACKOUT, GREYOUT, REDOUT	no	
TIME AT CONTROLS THIS FLIGHT	0		VERTIGO	no	
TOTAL FLIGHT TIME	127.3		NIGHT BLINDNESS	no	
TOTAL FLIGHT TIME IN MODEL	89.6		FATIGUE	no	
NUMBER PREVIOUS ACCIDENTS	none		DOMESTIC DIFFICULTIES	no	
DATE OF LAST ACCIDENT	—		UNFAMILIARITY IN TYPE AIRCRAFT	no	
NUMBER DAYS GROUNDED IN LAST MONTH	0		ANXIETY REACTION	no	
DATE LAST LOW PRESSURE INDOCTRINATION	8-21-57		LAST TER (date and score) 1-21-57	+16	
AMOUNT SLEEP IN LAST 24 HOURS	7 hrs.		OTHER PERTINENT FACTORS IN ACCIDENT (describe below)		

15. COMMENTS ON ITEMS CHECKED UNDER ITEM 14 WHICH ARE PERTINENT TO ACCIDENT/INCIDENT. WHERE APPLICABLE, COMMENT BELOW ON ANY OF THE ABOVE FACTORS AFFECTING CREW MEMBERS OR PASSENGERS

No sociological, psychological, physiological

Enclosure (6) to NAAS Whiting Field Aircraft Accident Report No. 6-58

(a) INCLUDE SURVIVORS NARRATIVES

OPNAV FORM 3750.8 (REV. 2-54)

SUMMARIES OF SAFETY EQUIPMENT, INJURIES AND CAU

DIRECTIONS

1. Use separate form for each person.
2. Under Injury Class, use following key:

Class "A" Fatal injury, is considered for reporting procedure as one that results in death prior to submission of the Aircraft Accident Report.
Class "B" Critical injury is considered for reporting procedure as injury which threatens to result in death either from injuries sustained in the accident or from complications thereof. Critical injuries resulting in death within 30 days shall be reported by letter to the original addressees.
Class "C" Serious injury is considered for reporting procedure as injury less than critical but detrimental requiring five or more days hospitalization involving medical treatment but from which the individual will be expected to recover. Unexpected critical conditions or complications arising

listed in this category which result in death within 30 days shall be reported by letter to the original addressees.
Class "D" Minor injury is considered for reporting procedure as any injury less than serious.
Class "E" No injury.
Class "F" Unknown injury - lost and presumed drowned.
Class "W" Unknown injury - missing.

3. Under Disposition, use following key:
"U" - Uninjured
"G" - grounded
"W" - treated and returned to duty
"H" - hospitalized
"D" - remains recovered
"D" - remains not recovered

1. NAME	2. FILE NO.	3. RANK/RATE	4. AGE	5. WEIGHT	6. HEIGHT
(b) (6) [redacted]	(b) (6) [redacted]	Nav Cad	23	170	71"

7. SEAT OCCUPIED AT TIME OF ACCIDENT: Front Cockpit

8. INJURY CLASS: D

10. DISPOSITION: X

11. SAFETY EQUIPMENT

SHOULDER HARNESS	NAF 502023-6	X	X	
LAP BELT	NAF 1201-88	X	X	
INERTIA REEL	NAF 315 074 1027	X	X	
"G" SUIT		NOT		X
HELMET	H-4	X	X	
OXYGEN MASK	A-14	X		X
GOGGLES	II	X	X	
SHOES (type)	Boondockers	X	X	
FLIGHT SUIT, OTHER THAN "G" (type)	Summer	X	X	
EXPOSURE SUIT (type)		NOT		X
OTHER (specify)				

PREOXYGENATION: ☐ YES ☐ NO

IF YES, OXYGEN SUPPLY PRESSURE PRIOR TO FLIGHT ____ PSI

AT TIME OF ACCIDENT ____ PSI

WAS OXYGEN EQUIPMENT PRE-FLIGHTED BY PILOT: ☐ YES ☒ NO

IF SHOULDER HARNESS USED	LOCKED	UNLOCKED	TIGHT	SLACK
	X		X	

☒ PRESSED FORWARD AGAINST HARNESS ☐ PRESSED AGAINST SEAT BACK

ON IMPACT	SAFETY BELT	LOCKED	TIGHT	SLACK
		X	X	

12. COMMENT ON EFFECTIVENESS (Entries of "No," "None," "as designed," etc., will not be accepted. If any equipment failed, describe failure and probable cause). Use additional sheet, if necessary.

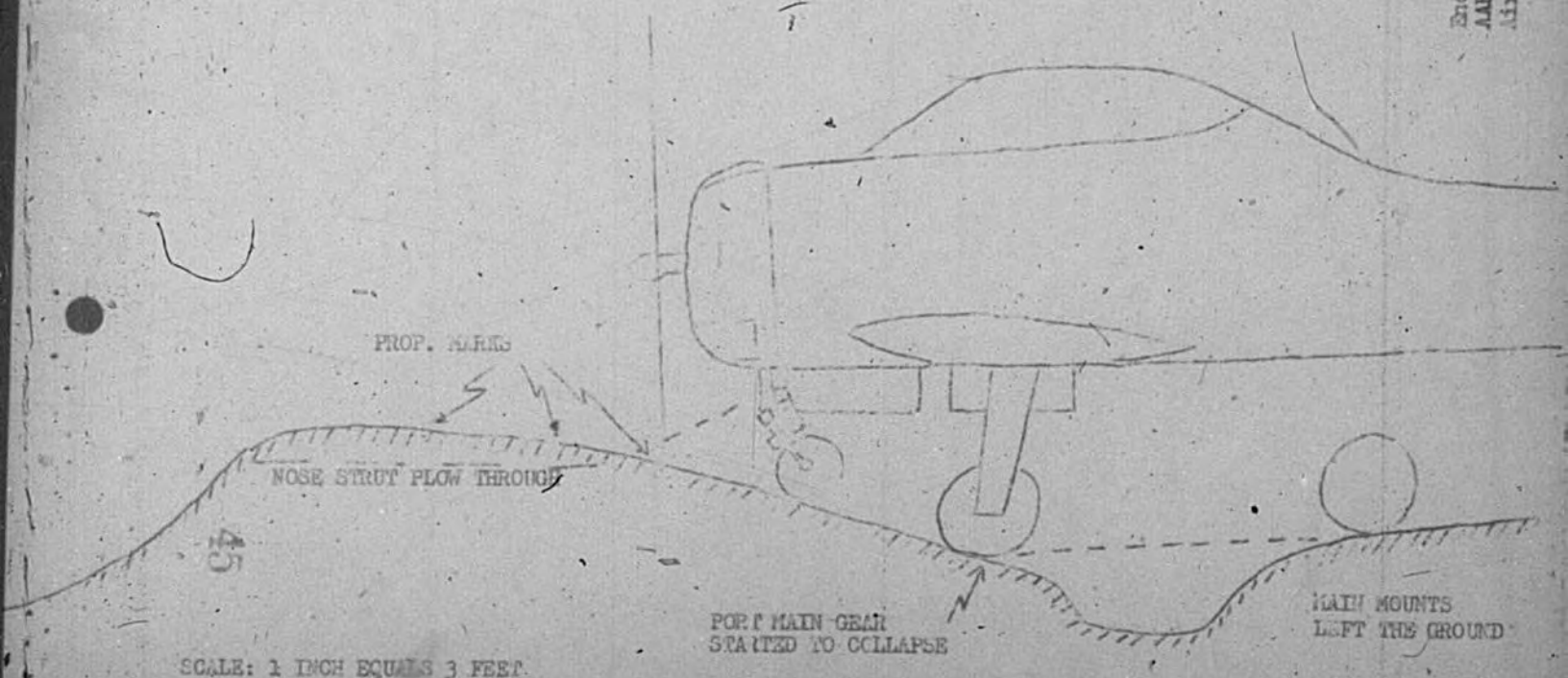
All safety equipment proved effective

IN CASE OF BURNS, FREEZING, OR FROSTBITE, LIST ALL CLOTHING WORN. USE ADDITIONAL SHEET, IF NECESSARY.

(b) (6) [redacted]

ENCL 4A TO NAAS
WHITING FIELD AAR
6-58 SHOWING IMPACT
DAMAGE

ENCL 4B TO NAAS WHITING FIELD AAR 6-58 SHOWING PILOTS EXIT OF ESCAPE.



Encl. (5) to NAS Whiting Fld.
AAR 6-58 Sketch showing how
Aircraft hit drainage ditch.