



O11:WB:br  
5830  
Ser 182  
26 FEB 1969

SECOND ENDORSEMENT on LCDR (b) (6) USN, 627985/1310 investigation report of 20 February 1969

From: Commander, Fleet Air Mediterranean/Commander, Antisubmarine Warfare Force, U. S. Sixth Fleet  
To: Judge Advocate General

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft Bureau Number 50878 in Hangar 2, U. S. Naval Air Facility, Naples, Italy

1. Readdressed and forwarded.
2. The proceedings, findings of fact, opinions and recommendations of the investigating officer and the endorsement thereon are approved.

Copy to:  
NAF Naples

*E. C. Outlaw*  
E. C. OUTLAW



6920043

*Death  
Crushed  
5 Feb 69  
Cinj 4 Feb 69)*

Veterans Administration  
Records Development Section  
03201  
Step 73  
*Hansen*

77

157119

NAVAL MESSAGE

NAVY DEPARTMENT

PRIORITY  
P 051502Z FEB 69  
FM NAVHOSP NAPLES

**EFTO**

TO SECNAV

INFO CHNAVPERS  
BUMED  
CINCUSNAVEUR  
COMFAIRMED  
COMSIX  
NAF NAPLES  
NAVSUPACT NAPLES  
NAVFINCEN CLEVELANT OHIO

UNCLAS E F T O

PERSONNEL CASUALTY REPORT  
A. BUPERSMAN ART C-9801

1. IAW REF A, FOL INFO IS SUBMITTED:

ALPHA: GARY D. HOLLAND, AN/USN, B33 52 91

BRAVO: ~~ACTIVE DUTY~~

CHARLIE: DECEASED - DEATH RESULTED FROM INJURIES SUSTAINED WHILE WORKING ON VC-54S AIRCRAFT

DELTA: 5 FEB 1969 - 1120 - U.S. NAVHOSP, NAPLES, ITALY

CIRCUMSTANCES: DIED OF INJURIES SUSTAINED WHEN NOSE WHEEL STRUT OF A/C HE WAS WORKING ON FAILED AND COLLAPSED, THUS PINNING HIM TO THE SIDES AND TOP OR BACK OF NOSE COMPARTMENT.

CAUSE: CERBRAL ANOXIA DUE TO CRUSHING INJURY OF CHEST.  
ECHO: REMAINS HELD AT NAVHOSP NAPLES ITALY PENDING INSTRUCTIONS FROM NOX

FOXTROT: (b) (6) - (b) (6)

GOLF: NOK HAS NOT BEEN OFFICIALLY NOTIFIED

HOTEL: IN LINE OF DUTY - NOT DUE TO OWN MISCONDUCT

INDIA: NAVPERS 601-2 VERIFIED ON 25 NOV 68.

JULIETT: (1) (b) (6) (HER)

(b) (6) (2) REG COMSIX DISIGNATE ACTY TO PAY DEATH GRATUITY

(3) (b) (6) (MOTHER)

MED(2)/PERS(1) . . .ACT  
09B2(2) 10(5) 007(2) FP(3) BFR(1) JAG(5) NAVREL(3) +

04841A  
028

CONTROL NO.	PAGE OF PAGE	TIME OF RECEIPT	DATE TIME GROUP
C07468/1/SC/	1 2	05/1714Z	051502Z FEB 69

NAF NAPLES:LE:JAB:rig  
5830  
Ser 220

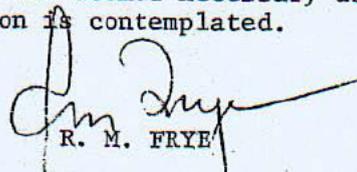
21 FEB 1969

FIRST ENDORSEMENT on LCDR (b) (6) USN, 627985/1310 investigation report of 20 Feb 1969

From: Commanding Officer, U. S. Naval Air Facility, Naples, Italy  
To: Judge Advocate General  
Via: (1) Commander Fleet Air Mediterranean/Commander, Antisubmarine Warfare Force, U. S. Sixth Fleet  
(2) Commander in Chief, U. S. Naval Forces Europe

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft Bureau Number 50878 in Hangar 2, U. S. Naval Air Facility, Naples, Italy

1. Readdressed and forwarded.
2. The proceedings, findings of fact, opinions and recommendations of the investigating officer in this case are approved.
3. The Commanding Officer, U. S. Naval Air Facility, Naples has taken the following action toward implementation of the recommendations of the Investigating Officer:
  - a. By endorsement to this command's Aircraft Accident Board investigation of subject incident, the Naval Safety Center is requested to publicize to all C-54 aircraft operators (U. S. Navy and U. S. Air Force) the potential hazard of using a nose wheel ground lock which does not have a safety clip as prescribed in the C-54 Flight Manual and Handbook of Maintenance Instructions.
  - b. A Technical Information Maintenance Instruction (TIMI 2-69) has been promulgated within the Operations Maintenance Division of this command for the purpose of emphasizing to all Operations Maintenance Division personnel as well as to other maintenance personnel the importance of landing gear ground lock pins, including the exclusive use of regulation ground lock pins.
  - c. The Maintenance Training Program of this command is being revised to place more emphasis on all aspects of safety, with particular stress on the potential dangers involved in the maintenance of aircraft landing gear and wheel well accessories.
4. In concurrence with the Investigating Officer's recommendation that disciplinary action is not deemed necessary as a result of this investigation, no such action is contemplated.

  
R. M. FRYE

20 FEB 1969

From: LCDR (b) (6), USN, 627985/1310  
To: Commanding Officer, U. S. Naval Air Facility, Naples, Italy

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft Number 50878 in Hangar 2, U. S. Naval Air Facility, Naples, Italy

Ref: (a) JAG Manual

- Encl:
- (1) Appointing Order
  - (2) Statement of Witness: LT (b) (6), 690257, USNR
  - (3) Statement of Witness: HMC (b) (6), 471 06 54, USN
  - (4) Statement of Witness: (b) (6), GS-9
  - (5) Statement of Witness: HM2 (b) (6), (b) (6), USN
  - (6) Statement of Witness: AMS3 (b) (6), (b) (6), USN
  - (7) Statement of Witness: ADJ2 (b) (6), (b) (6), USN
  - (8) Statement of Witness: ASC (b) (6), (b) (6), USN
  - (9) Statement of Witness: LCDR (b) (6), 397657/1312, USN
  - (10) Statement of Witness: ADRI (b) (6), (b) (6), USN
  - (11) Statement of Witness: LT (b) (6), 668080/1310, USN
  - (12) Statement of Witness: AE1 (b) (6), (b) (6), USN
  - (13) Statement of Witness: AMSC (b) (6), (b) (6), USN
  - (14) Statement of Witness: AMH1 (b) (6), (b) (6), USN
  - (15) Statement of Witness: AMSAA (b) (6), B54 49 49, USN
  - (16) Statement of Witness: ADR2 (b) (6), (b) (6), USN
  - (17) Statement of Witness: LCDR (b) (6), 627985/1310, USN
  - (18) Statement of Witness: AMH1 (b) (6), (b) (6), USN
  - (19) Statement of Witness: PH1 (b) (6), (b) (6), USN
  - (20) Statement of Witness: Division Chief Petty Officer, AMSC (b) (6), (b) (6), USN
  - (21) Statement of Personnel Officer: CWO-2 (b) (6), 697406/7822, USN
  - (22) Statement of Division Officer: LCDR (b) (6), 397657/1312
  - (23) Statement of close friend: TNAN (b) (6), (b) (6), USN
  - (24) Statement of Operational Maintenance Transit Line Division Chief Petty Officer, ABHC (b) (6), (b) (6), USN
  - (25) Certified Copy of: Planner and Estimator report of damages to VC54Q BuNo 50878
  - (26) Certified Copy of: Record of practical factors of AMSAN Gary D. HOLLAND, B33 52 91, USN
  - (27) Death Report Form: NAVJAG 5800/16 (5-68)
  - (28) Certified Copy of Autopsy Report: Standard Form 503
  - (29) Certificate of Death: Form NAVMED N (Rev 4-58)
  - (30) Photograph: Accident Scene (aircraft in nose down position)

- (31) Photograph: Accident Scene (aircraft nose wheel well, position of ground lock safety pin)
- (32) Photograph: Aircraft Nose Wheel Well (simulated position of AMSAN Gary D. HOLLAND, B33 52 91, USN at the time of the accident)
- (33) Photograph: Aircraft Nose Wheel Strut (lower clamp power steering hydraulic lines)
- (34) Photograph: Aircraft Cockpit Compartment (landing gear handle selector)
- (35) Photograph: Ground Lock Safety Pin (in use at time of accident)
- (36) Photograph: Regulation Ground Lock Safety Pin
- (37) Photograph: Regulation Ground Lock Safety Pin (with safety clip installed)
- (38) Photograph: Damage to Aircraft (right forward fuselage)
- (39) Photograph: Damage to Electric Power Unit
- (40) Photograph: Damage to Aircraft (number (2) engine propeller)
- (41) Photograph: Damage to Aircraft (number (3) engine propeller)
- (42) Photograph: Aircraft Nose Wheel Well (down lock linkage micro switch)

#### PRELIMINARY STATEMENT

1. In accordance with reference (a) and as directed by enclosure (1) on 4 February 1969 I was appointed as investigating officer for subject accident. I was advised on procedure by Acting Legal Officer, LT (b) (6), 640402/6602, USN, Assistant Administrative Officer of the U. S. Naval Air Facility, Naples, Italy who is not a lawyer in the sense of Article 27, UCMJ. I began the investigation at once.
2. During the course of the investigation legal advice was obtained from LTJG (b) (6), 713337/1105, USNR assigned as Legal Officer of the U. S. Naval Air Facility, Naples, Italy, who is a lawyer in the sense of Article 27B(1), UCMJ.
3. The investigation was conducted in an unbiased and objective manner. No difficulties of note were encountered in compilation of evidence required for subject investigation other than mentioned below.
4. Medical information in Death Report, Form NAV/JAG 5800/16 (5-58), front line 6, Enclosure (27), and Certificate of Death, NAVMED N(Rev 4-58), back, paragraph 30, Enclosure (29), indicate that the time of first examination by a Medical Officer was about 1230, 4 February 1969. The investigation has revealed that the correct time of first examination was approximately 1330 vice 1230. This information has been brought to the attention of the originators of the above reports. The JAG report is forwarded with original medical reports to avoid undue delay.

FINDINGS OF FACT

1. That Gary Doyle HOLLAND, AMSAN, B33 52 91, USN, assigned to the Operations Maintenance Division Airframes Shop of the U. S. Naval Air Facility, Naples, Italy, was fatally injured at approximately 1248 local time on 4 February 1969. Enclosures (2), (27), (28), (29).
2. That the fatal injuries were received in the nose wheel collapse of U. S. Navy aircraft VC 54Q Buno 50878 located in hangar No. 2, NAF Naples at the time of subject accident. Enclosures (27), (28), (29).
3. That immediate action was taken to free HOLLAND by placing men in the tail section and lifting the nose with a 20,000 lb forklift secured to nylon tow straps placed around the fuselage. Enclosures (2), (3), (4), (5), (8), (12), (30).
4. That HOLLAND was removed from the nose wheel well in 12-15 minutes and immediately administered mouth-to-mouth resuscitation and external heart massage by medical corpsmen for approximately ten (10) minutes prior to and five (5) minutes during the helo lift to the U. S. Naval Hospital, Naples, Italy, where open heart massage was immediately performed. Enclosures (3), (5), (9), (10), (11), (29).
5. That HOLLAND succumbed at 1120 on 5 February due to crush injuries to the chest and brain anoxia. Enclosures (27), (28), (29).
6. That due to the accident, aircraft VC54Q BuNo 50878 received substantial damage to the fuselage, nose wheel well doors and number (2) and (3) engine propellers. Enclosures (25), (30), (38), (39), (40), (41).
7. That HOLLAND was in a duty status at the time of the subject accident. Enclosures (21), (22).
8. That HOLLAND was assigned by (b) (6), AMH1, (b) (6), USN the task of securing mounting clamps for the nose wheel steering hydraulic lines and tightening the bolts which hold the down micro switch to the downlock linkage approximately 50 minutes before the subject accident occurred. Enclosures (14), (33), (42).
9. That at the time of the accident HOLLAND was working alone in the nose wheel well, however, had shortly before received assistance from (b) (6), AMSAA, B54 49 49, USN, in securing the lower clamp for the nose wheel steering hydraulic lines. Enclosures (15), (33).
10. That HOLLAND had just entered the nose wheel well moments before the nose wheel collapsed. Enclosure (15).

11. That the ground lock safety pin was noted by two witnesses to be inserted in the down lock linkage two (2) to three (3) hours prior to the subject accident. Enclosures (14), (16), (42).
12. That the ground lock safety pin was noted by one (1) witness to be inserted from the left to the right side. Enclosures (16), (31).
13. That the ground lock safety pin in use was non-regulation, fit very loosely and could be inserted from either direction. Enclosures (17), (18), (35), (36), (37).
14. That this same ground lock safety pin had been used on the aircraft at least since 1 October 1968. Enclosure (16).
15. That at the time of the accident two (2) men were working on the number one (1) engine, and two (2) men were working in the admiral's compartment. Enclosures (3), (7), (16).
16. That the nose wheel collapsed slowly and the fall was broken by the starboard side of the fuselage contacting an electric power unit and the number (2) and (3) engine propellers contacting the hangar deck; which prevented the complete retraction of the nose wheel and much more severe crushing of the victim. Enclosures (6), (30), (38), (39), (40), (41).
17. That the gear handle selector was in the down and latched position when the cockpit was entered after the subject accident. Enclosures (19), (34).
18. That the aircraft was not on jacks at the time of subject accident. Enclosures (6), (14).
19. That installation of a new nose strut on the aircraft was completed on 1 February 1969, at which time the landing gear was considered to be structurally sound and stable and supporting jacks were removed to facilitate easy movement in event of a hangar fire. Enclosures (13), (14).
20. That the work in progress on the aircraft (securing accessory clamps and micro switch) by normal maintenance standards, did not require it to be supported by jacks. Enclosures (13), (14).
21. That the investigating officer readily dislodged the ground lock safety pin completely (with no intentional effort) by entering the nose wheel well and simulating the assigned work of HOLLAND. Enclosures (13), (14), (15), (17), (32).
22. That the down lock linkage when tested by the investigating officer could be lifted (unlocked) with virtually no effort when pressure was applied as described and depicted. Enclosures (17), (32).

23. That HOLLAND had recently assisted AMHL (b) (6) in the removal and installation of the nose gear strut of subject aircraft. Enclosures (13), (14).
24. That HOLLAND was a recent graduate of the following formal schools: Aviation Fundamentals "P" School, Aviation Maintenance Fundamentals "A" School, and Aviation Metalsmith "A" School. Enclosure (21).
25. That HOLLAND had approximately two (2) months of practical experience in the Operational Maintenance Division Airframes Shop and completed his practical factors for advancement to AMS3 on 13 January 1969, which verifies demonstrated proficiency in observing safety precautions applicable to aviation structural work, including aircraft landing gear. Enclosures (21), (26).
26. That HOLLAND conscientiously worked hard at assigned tasks, however, was occasionally noted to disregard safety regulations. Enclosure (20).
27. That the interview by the investigating officer of HOLLAND's closest friend revealed no personal problems or temporary mental condition which could be instrumental in subject accident. Enclosure (23).

#### STATEMENT OF OPINION

1. That HOLLAND in the performance of his assigned duty accidentally retracted the nose wheel safety pin flush with the right side of the down lock linkage as he entered the right rear side of the nose wheel well. After getting into the position depicted in enclosure (32), so he could tighten the down-micro-switch mounting bolts, hydraulic connection, or clamp indicated in enclosure (31) as stated by enclosures (13), (14), (15), he reached under the red flagged safety pin or bumped it with his forearm and completely dislodged the pin. Upon seeing the pin dislodged he repositioned his body to re-insert the safety pin and in so doing he applied sufficient force with the thigh of his leg to break the lock mechanism of the down lock linkage, thus allowing the nose gear to collapse.
2. That HOLLAND's recent formal instruction, enclosures (21), (26), covering the basic operation of aircraft landing gear, the functions of safety pins and necessary precautions which should be taken when performing maintenance of this nature, qualified him to perform such work as was assigned without direct and immediate supervision.
3. That the accident would not have occurred if a regulation safety pin with safety clip installed, enclosure (37), had been in use and if the party had been more acutely aware of the potential danger involved when the safety pin was dislodged.
4. That based on enclosure (24), and the investigating officer's interview of numerous VC-54 aircraft ex-crewmembers including one of the previous COMIDEASTFOR pilots, it is a common Navy and Air Force procedure to use a non-regulation safety pin, in that, a safety clip is not installed. Considering that the pin in use is virtually identical to the regulation

pin, with the exception that there was no safety clip attached, it would not be expected that the crewmembers or shop maintenance personnel would have noted or questioned the suitability of the pin.

5. That the death of HOLLAND was not caused by the intent, fault, negligence or inefficiency of any person or persons in the Naval Service or connected therewith.

#### RECOMMENDATIONS

1. That appropriate action be taken to insure dissemination of all pertinent information of subject accident to all Navy and Air Force operators of subject type aircraft.
2. That appropriate action be initiated to insure that regulation ground lock safety pins are installed in all aircraft (transient included) prior to performance of any maintenance functions by Naval Air Facility personnel.
3. That appropriate action be initiated to insure current training procedures be modified to more strongly stress the potential danger involved in the maintenance of aircraft landing gear and wheel well accessories.
4. That disciplinary action is not deemed necessary as a result of this investigation.

(b) (6)

DEPARTMENT OF THE NAVY

U. S. Naval Air Facility

FPO New York 09520

In reply refer:

NAF NAPLES: 5830

LE:RHB:mh

Ser

171

5 Feb 1969

From: Commanding Officer, U.S. Naval Air Facility, Naples, Italy  
To: Lieutenant Commander (b) (6), USN, (b) (6)/1310

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft number 50878 in Hangar 2, U.S. Naval Air Facility, Naples, Italy

Ref: (a) Verbal order of 4 February 1969  
(b) JAG Manual

1. As directed by reference (a), and in accordance with reference (b), you were appointed to conduct an informal investigation on 4 February 1969, or as soon thereafter as practicable, for the purpose of inquiring into all the circumstances connected with subject accident.
2. You will conduct a thorough investigation into all the circumstances connected with the subject accident and report your findings of fact, opinions and recommendations as to the cause of subject accident, the resulting damage, the circumstances attending death of a member of the naval service, and responsibility for the accident, including any recommended administrative or disciplinary action.
3. You will be furnished the necessary reporters and clerical assistance for recording and transcribing the testimony of witnesses and assisting you in preparing the report of the results of your investigation. In preparing and submitting your report, you will be guided by the provisions of reference (b).

(b) (6)

(b) (6)

ENCLOSURE

4 February 1969

Statement of (b) (6), LT, USNR, 69 02 57,  
assigned as co-pilot of COMIDEASTFOR Flag Aircraft VC54Q BUNO 50878.  
I did observe the following on 4 February, 1969.

At approximately 1248 (local) 4 February 1969 LCDR (b) (6)  
USNR, 438233/1315 and I were standing just outside the NAF Naples  
hangar #2 and had been observing a USAF C-141 aircraft rolling out,  
after landing (above time verified by NAF Naples tower as landing  
time of the C-141). Out of the corner of my eye I noticed the tail  
of the COMIDEASTFOR flag aircraft, VC54Q BUNO 50878, raising up, and  
turning around to see the aircraft, realized that the nose gear had  
collapsed. The aircraft was settling onto the nose wheel as I  
turned around. I had just walked from the nose of the aircraft and  
had seen a man working up in the nose wheel well. I immediately ran  
to the nose of the aircraft to try to ascertain if the man was still  
in the wheel well. Many men converged at the nose of the aircraft  
and one of the man's feet could be seen up in the well. Approximately  
10 minutes later a fork lift arrived and after a sling had been  
placed under the aircraft, the nose was raised enough to extricate  
the man from the wheel well. I saw the nose gear safety pin with red  
flag still attached laying on the deck directly below the nose gear  
after the man had been removed. I did not see this pin fall from  
inside the wheel well. Artificial mouth-to-mouth resuscitation was  
begun by the corpsman as soon as the man was taken from the wheel  
well and placed on a stretcher, and continued until he was placed  
aboard a waiting helicopter.

I have read the above statement, consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6) LCDR, USN

ENCLOSURE <sup>2</sup>

4 February 1969

Statement of (b) (6), GS-9,  
assigned as Station Fire Chief of the Operations Fire and Crash  
Division, U. S. Naval Air Facility Naples, Italy, I did observe the  
following on 4 February 1969.

I was headed to the hangar from the Chief Petty Officer lounge and  
noticed the aircraft up on its nose. It had evidently just nosed  
over because there was no activity of personnel or action taking  
place at that time around the aircraft.

When I entered the hangar the fire trucks were arriving and  
personnel were starting to remove the S2F aircraft from the hangar.  
I heard someone yell that there was a man trapped in the wheel well  
so I told (b) (6), AEC, (b) (6), USN and (b) (6)  
(b) (6) ADGS, (b) (6), USN to have someone get a fork lift from  
Ground Support Building and to have it enter the hangar from the  
road side entrance.

(b) (6), DC2, (b) (6), USN was told to return to the  
Fire Department building and bring an aircraft lifting bag with  
an air compressor to the nose of the aircraft. When the fork  
lift arrived I noticed the lifting fork blades were missing from  
the forklift. AEC (b) (6), and (b) (6), ABHC, (b) (6),  
USN were instructed to place men in the tail section of the  
aircraft. A work stand was placed by the cargo door and about  
20 men entered the aircraft.

Cargo straps were placed around the nose section and attached to the  
boom of the forklift which raised the aircraft to a resting position  
on the aircraft tail support post.

The man was removed from the nose wheel well and placed upon a  
stretcher. The medical personnel took charge of the injured man.  
I notice the nose wheel locking pin was missing and asked several  
people if they knew about it. The first I saw of the pin was when  
it was in the hands of (b) (6), AMSC, (b) (6), USN, while  
he was talking to LCDR (b) (6), (b) (6), USN.

The crash equipment was secured.

The total time to raise the aircraft and remove the injured man was  
roughly 12-15 minutes.

I have read the above statement consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6) LCDR, USN

ENCLOSURE 4

4 February 1969

Statement of (b) (6) HM2, (b) (6) USN assigned to Medical Department of the U. S. Naval Air Facility, Naples, Italy. I did observe the following on 4 February, 1969.

I received a telephone call from (b) (6), AT1, (b) (6), USN, at 1253 that a man was trapped in the front wheel deck of an aircraft. (b) (6), HMC, (b) (6), USN and I arrived on the scene in the NAF hangar #2 at 1255. We both tried to reach the man that was trapped and tried to communicate with him to no avail. Captain (b) (6) (b) (6) /2200, USN(DC) and LT. (b) (6), (b) (6) /2200, USN(DC), arrived at the scene shortly afterwards. It took the crew approximately 10 minutes to free the man.

HMC (b) (6) started giving mouth-to-mouth resuscitation immediately. I started giving external cardiac massage. Patient was already cyanotic at this time. He had ceased breathing as far as we could determine at that time. Dr. (b) (6) relieved me while I set up oxygen. We then used the res-cu-air apparatus. He appeared to have had a cardiac arrest. After approximately 15 minutes of artificial respiration and cardiac massage the patient was helo lifted to the U. S. Naval Hospital, Naples. Just prior to lift off patient was given (0.5cc) of 1:1000 solution of epinephrine directly into the heart muscle. We continued artificial respiration and cardiac massage until we were relieved at U. S. Navy Hospital at approximately 1320.

I have read the above statement, consisting of this (1) page and it is true to the best of my knowledge and belief.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)

(b) (6) LCDR, USN

4 February 1969

Statement of (b) (6); AMS3 (b) (6), USN,  
assigned as Aircraft Maintenance Department Material Screening Petty  
Officer of the U. S. Naval Air Facility Naples, Italy. I did  
observe the following on 4 February 1969.

I had just called the Avionics Shop from the Airframes Shop for a  
parts pick up. I was standing on the port side of the nose wheel  
(aircraft VC54Q, BUONO 50878) when all at once the nose of the  
aircraft came down. It didn't come down real fast but the man  
didn't have a chance of getting out. So I started to help the  
rest of the men move other aircraft out of the barn. There  
was no nose jack under it. I started to run to the fire alarm, but  
somebody beat me. I also yelled that there was a man in the nose  
section.

I have read the above statement, consisting of this (1) page and  
it is true to the best of my knowledge and belief.

Witnessed:

(b) (6)

(b) (6) LCDR, USN

(b) (6)

(b) (6) *AMS 3*

ENCLOSURE *1*

4 February 1969

Statement of (b) (6), ADJ2, (b) (6), USN,  
assigned to the Operations Maintenance Division Engine Shop of  
the U. S. Naval Air Facility, Naples, Italy. I did observe  
the following on 4 February, 1969.

(Aircraft 50878), (b) (6), ADR2, (b) (6), USN and I  
were working off Q. A. discrepancies on the number (1) one  
engine. (b) (6) had his head inside the accessory section when  
the aircraft started to nose over, at that time OTTO kicked  
myself and tool box off the stand and we both ran away from  
the aircraft. At that time the aircraft was completely  
down on the nose. I did not see anyone else working at that  
time on the aircraft. The aircraft settled slowly on the nose.  
This happened after chow sometime.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)  
(b) (6), LCDR, USN

4 February 1969

Statement of ASC (b) (6), USN, (b) (6), assigned as Chief Petty Officer in Charge of the Aircraft Maintenance Department Support Shop of the U. S. Naval Air Facility, Naples, Italy. I did observe the following on 4 February 1969.

I was coming through the Aircraft Maintenance Office when I heard a loud crashing noise on the hangar deck. I ran out the door and saw the C54 aircraft on its nose and someone yelled there was a man under it. I went to Ground Support and got the 20,000 lb forklift and had a man get some parachute harness that was in the shop, used for tow rope. I went to the hangar and to the nose of the plane. They rigged a strap around the windows in the cockpit and I picked the plane up, with the help of people in the tail of the plane.

I have read the above statement, consisting of this (1) page and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6)

, LCDR, USN

ENCLOSURE ...

4 February 1969

Statement of (b) (6), LCDR, (b) (6)/1312, USN, assigned as Operations Maintenance Division Officer of the U. S. Naval Air Facility, Naples, Italy. I did observe the following on 4 February 1969.

At approximately 1245 this date I was standing in front of the hangar observing personnel at work when all of a sudden I observed the tail of C-54 BUNO 50878 rise into the air and the nose gear folding. Knowing that personnel were working in the nose wheel well I rushed to the scene to see if anyone was in it. It was too dark in the wheel well to determine if anyone was in it. I saw (b) (6), AMSC, (b) (6), USN, rushing to the scene and he informed me that Gary D. HOLLAND, AMSAN, B33 52 91, USN, was in the wheel well. By this time (about 1247) many personnel were converging on the scene. I immediately directed someone to sound the fire alarm in order to clear the hangar of aircraft and have assistance available to remove HOLLAND and fight fire in event that there was fuel spillage. I then rushed next door and informed Captain (b) (6), (b) (6), USN, the Commanding Officer of U. S. Naval Air Facility Naples, who proceeded immediately to the scene. The aircraft was uprighted about 1300 by placing straps around the nose and lifting with a forklift and putting personnel in the tail to decrease the weight on the nose. When HOLLAND was removed from the wheel well I noticed the safety pin lying on the hangar deck.

I have read the above statement consisting of this (1) page and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6)

, LCDR, USN

4 February 1969

Statement of (b) (6), ADRI (b) (6), USN,  
assigned to the Operational Maintenance Division Check Crew Shop  
of the U. S. Naval Air Facility, Naples, Italy. I did observe  
the following on 4 February 1969.

About 1250 plus or minus a few minutes I was standing in the  
Check Crew Shop smoking a cigarette and talking to (b) (6)  
(b) (6), ADRI, (b) (6), USN, I heard a loud crash and  
looked out the door and saw aircraft 50878 setting on its nose.  
I dropped my cigarette and ran to the nose of the aircraft at  
which time I crawled under the nose wheel well and saw a leg  
hanging down.

Someone behind me said it was Gary D. HOLLAND, AMSAN B33 52 91,  
USN, so I started talking to him. He did not answer me, but  
he was trying to get out. I told him to lay still and not to  
move. I ask him if he could hear me to move his right foot  
which was all I could see. He wiggeled his foot back and forth  
a few times so I told him to lay still again and not move.  
Then I just started talking to him. I don't remember what I  
said, I just wanted to keep talking to try to distract him.  
About one minute later I asked him to move his foot if he  
could still hear me, he moved his foot a very slight amount.  
So I started talking to him again. About the time the  
forklift got there I asked him once again to move his foot  
if he could hear me, he did not move so I crawled out from  
under the wheel well.

I have read the above statement consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6)

LCDR, USN

ENCLOSURE 16

4 February 1969

Statement of (b) (6), LT, 668080/1310, USN,  
assigned as Operational Maintenance Quality Assurance Officer, U. S.  
Naval Air Facility, Naples, Italy. I did observe the following on  
4 February 1969.

Upon hearing the hangar deck fire alarm I walked out into the hangar.  
I saw the COMIDEASTFOR VC-54 aircraft sitting on its nose with the  
nose gear collapsed. (b) (6), AMSC (WC 120) told me there  
was a man in the wheel well. I then directed men to get the cherry  
picker and cargo straps so we could lift the nose. I thought it  
inadvisable to load the rear of the aircraft, because the man might  
be crushed when the wheel came down.

The incident happened about 1250 and the man was freed at about 1300.  
The aircraft was finally secured at about 1315. A combination of men  
in the tail of the aircraft and the fork lift raised the aircraft.

The nose gear pin was not installed in the aircraft when it raised.

I have read the above statement, consisting of this one (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6), LCDR, USN

ENCLOSURE 11

10 February 1969

Statement of (b) (6), AE1, (b) (6), USN, assigned to the Aircraft Maintenance Department Electric Shop of the U. S. Naval Air Facility Naples, Italy. I did observe the following on 4 February 1969.

At approximately 1245 on February 4, 1969, I was about to leave the head located on the hangar deck, when I heard a loud crash or crunch, upon reaching the hangar deck the aircraft had already settled on its nose, the wings were still bouncing. I started running toward the nose of the aircraft I observed (b) (6), ADR2, (b) (6), USN, running toward the fire alarm hollering fire. The next thing I observed was (b) (6), ADR1, (b) (6), USN, hollering that there was a man trapped in the nose wheel well. ADR1 (b) (6) was trying to gain access to the nose wheel well through the aft portion, by the battery compartment. Being unable to gain access this way he was hollering for the man to answer, telling him to be still and don't move.

By this time there were numerous people on the hangar deck, people started getting other aircraft out of the hangar bay. At this time I joined a group of men and started moving check stands, cowling, etc. from around the nose area to clear it so rescue operations would not be hindered, also during this time (b) (6), AEC, (b) (6), USN, was instructing people to climb into the aircraft, going as far as possible to the aft to counter-act the nose weight and start the nose lifting.

The Fire Department and Medical Department arrived, (b) (6), HM2, (b) (6), USN, upon surveying and being informed of the situation, instructed me to make a call to U. S. Naval Hospital and instruct them to get a doctor here as soon as possible. I ran to the Aircraft Maintenance Department Maintenance Control to make the call. While making the call I checked the time by my personal watch, it was 1251. I made contact with the information desk of the hospital, informed them as instructed by HM2 (b) (6), then left the Maintenance Office and returned to the hangar deck.

(b) (6), ASC, (b) (6), USN, came in thru the firelane with a heavy duty forklift. Finally a decision was made as to how the aircraft was to be lifted. ASC (b) (6) positioned the lifter on the port side of the nose with the boom over the cockpit. At this time I climbed up on the boom and assisted (b) (6), ADR3, (b) (6), USN, in hooking up the straps and connecting them to the boom, upon completion we crawled back off the boom to the hangar deck on the port side of the nose of the aircraft. As the nose of the aircraft was lifted from the hangar deck, the nose wheel fell free. As the forklift ceased lifting I entered the nose wheel compartment from the port side. At this time 2 or 3 tools fell to the deck from the man's jacket pocket and from the strut braces.

I did not see a safety pin in place or hanging among the braces, or in the man's left hand jacket pocket which had contained the tools. My first observation of the man's physical appearance was that his extremities were not in any awkward or odd position for the human body, his legs were dangling down parallel with the nose strut. His right arm was at his side, his left arm and shoulder was draped through the "Y" brace on front of the strut. His head was slumped forward. The man's color was gone from his face and his lips were a deep bluish purple, there were air bubbles on his lips. The man showed no signs of life or breathing during my contact with his body. In trying to remove him from the braces, I found his foul weather jacket hooked on part of the strut, I physically tore the man's jacket, and he dropped from the braces to the arms of the men on the starboard side of the nose wheel.

I have read the above statement consisting of these two (2) pages, it is true to the best of my knowledge and belief.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)

(b) (6) LCDR, USN

4 February 1969

Statement of (b) (6), AMSC, (b) (6), USN, assigned as Operational Maintenance Division Airframes Shop Chief Petty Officer of the U. S. Naval Air Facility, Naples, Italy. I did observe the following on 4 February 1969.

The aircraft had just undergone work by Work Center 120 requiring the nose landing gear installation to be replaced. (b) (6), AMHL, (b) (6), USN was assigned to the job as supervisor and 500 labor including the removal and installation of this strut. He was assisted by Gary D. HOLLAND, AMSAN, B33 52 91, USN. The aircraft was in the second week of maintenance action on this project. The new strut was installed on aircraft with old yoke assembly, which had been removed from the old strut and repressed on by (b) (6). The actual installation of the new strut assembly was completed to the point that the aircraft could be safely towed, this was done on Saturday, February 1st, by (b) (6) AMHL and HOLLAND, AMSAN. The nose gear main attaching parts had been installed and the safety pins installed. The aircraft was in all structural aspects safe to be off jacks, as long as safety pins were inserted. The only work left was the attachment of minor accessory units, and the installation of three (3) bolts, two bolts for the nose wheel steering and one in a side brace (the old bolt was in place awaiting receipt of a new bolt). The afore mentioned bolts in no way affected the strength or stability of the nose gear. On reporting to work Monday morning I was informed by (b) (6), AMHL that the new strut installation was complete except for the afore mentioned three (3) bolts and minor accessory installations. The only thing that remained to be done was to drop check the aircraft after it was completely configured, to insure safety of flight. Due to the problem of a nose wheel steering cable being broken and the bolt that needed replaced, I was in the nose wheel well several times on Monday and I noticed nothing out of order, the gear was secured and the safety pin installed. On the day of the accident February 4 1969, (b) (6) and HOLLAND were assigned to continue the work of configuring subject strut. HOLLAND did not start on the job due to the 3rd class Petty Officer exams that morning. (b) (6) continued on other work involving steering components.

At approximately 1130 I went to the Chief Petty Officer Round House for lunch and returned to my work center at approximately 1225. On my way to the workcenter I noticed HOLLAND working in the nose wheel well, I asked him what he was doing, he stated that he was tightening a nut on the clamp that held the landing light wires on the upper strut yoke. I then proceeded to my work center, I was there approximately 10 minutes when I heard the crash of the aircraft when the gear collapsed. I immediately ran to the hangar and saw what happened, my first thought was for HOLLAND, I spread the alarm and stood by to assist in the lifting of the aircraft, when the aircraft was lifted and HOLLAND was removed my concern was where was the locking safety pin.

Someone (I believe the crash crew Chief Petty Officer) said the pin fell out of the aircraft when HOLLAND was removed. I found it in liquid which had run out of the aircraft by the starboard side of the nose wheel on the deck.

I have read the above statement, consisting of these (2) pages and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6)

LCDR, USN

4 February 1969

Statement of (b) (6), AMHI (b) (6), USN,  
assigned to the Operational Maintenance Airframes Shop of the U. S.  
Naval Air Facility Naples, Italy. I did observe the following on  
4 February 1969.

On the morning of January 23 it was determined by the Maintenance Chief  
(b) (6), ADRC, (b) (6), USN) and my Shop Chief, (b) (6)  
(b) (6), AMSC, (b) (6), USN, that the nose strut needed to be changed  
on COMIDEASTFOR C54 BUNO 50878.

Chief (b) (6), Gary D. HOLLAND, AMSAN, B33 52 91, USN and I were involved  
in pulling the strut. On Saturday 1 February 69 HOLLAND and I started to  
install the new strut. We were minus one bolt, but we found a temporary  
replacement, that would enable us to take the aircraft off jacks, so that  
in the event of fire the aircraft could be moved. Chief (b) (6) was here  
during this time and the aircraft was considered safe to drop off jacks.  
The jacks were removed and the station CDO (LCDR (b) (6)  
(b) (6)/6602 USN) notified.

Monday 3 February, HOLLAND and myself started putting the rigging (nose  
steering etc.) back. Tuesday 4 February 1969, HOLLAND was taking the  
PO3 exam in the morning and did not return to work until 1200. I went  
to chow at 1100 and returned at 1200. There were just a few items left  
that we could do until the three (3) bolts came in that we were AACP  
for one stbd support strut bolt and both nose wheel steering cylinder  
bolts.

At a few minutes after 1200 I assigned HOLLAND the job of 1. Tightening  
the clamps that hold the nose steering hydraulic lines rigid to the strut.  
2. Tightening the two (2) bolts that hold the down-micro-switch to the  
over center arm. I had previously installed the micro-switch and just  
started the nuts on the bolts, at this time (about 1000 hrs) I noted  
that the safety pin was installed. After I had assigned HOLLAND this  
work, I walked into the Airframes Shop and was having a smoke when the  
nose gear collapsed.

I have read the above statement, consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)  
(b) (6), LCDR, USN

4 February 1969

Statement of (b) (6), AMSAA, (b) (6), USN,  
assigned to the Operational Maintenance Air Frames Shop of the  
U. S. Naval Air Facility Naples, Italy. I did observe the following  
on 4 February, 1969.

It was about 1240, and AMSAN Gary D. HOLLAND, B33 52 91, USN and I  
were tightening the bottom clamp on the two hydraulic lines to the  
power steering. I started back into the shop and he started up  
into the wheel well to tighten the top connections and clamp of  
the power steering hydraulic lines. I just got back into the shop,  
(which was about 30 sec. to 1 minute time) and the plane crashed.

I have read the above statement, consisting of this (1) page and  
it is true to the best of my knowledge and belief.

(b) (6)

Witnessed:

(b) (6)

(b) (6)

4 February 1969

Statement of (b) (6), ADR2, (b) (6), USN,  
assigned to the Comideast Av-Unit as second mechanic on C54Q BUNO  
50878. I did observe the following on 4 February 1969.

I had been working in the nose wheel well between 0800 and 1130,  
4 February 1969. Before entering the wheel well I checked to  
see if the gear pin was installed. I found the pin in its  
proper place, inserted from the port side of the gear. Then I  
left the area. At about 1130 I re-checked the pin and it was still  
in place.

At approximately 1300 I entered aircraft 50878 to assist (b) (6)  
(b) (6), AE2, (b) (6), USN in fixing a light switch in the  
admiral's compartment. Several minutes later the aircraft began  
to settle on the nose. I immediately evacuated the aircraft  
through the front door. After the aircraft was lifted I noticed  
the red flag of the nose wheel pin fall from the front of  
HOLLAND's body. It came from about the chest or lap area.  
I was assigned to the flight crew of 50878 on October 1, 1968.  
The nose pin that is presently installed is the same one that  
has been on the Aircraft since my arrival.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6)

LCDR, USN

ENCLOSURE 16

5 February 1969

Statement of (b) (6), LCDR, (b) (6)/1310, USN, investigative officer of the subject accident, assigned as the Assistant Aircraft Maintenance Officer of the U. S. Naval Air Facility Naples, Italy. I did observe the following on 5 February 1969.

I entered the nose wheel well of aircraft BUNO 50878 and duplicated the efforts and position of HOLLAND as described in enclosures (13) (14) (15) (32). The aircraft was at this time supported by jacks, however the nose wheel was touching the deck and supporting some of the weight of the aircraft. As I climbed into position with the ground lock safety pin inserted from left to right as described in enclosure (16), I readily brushed the pin which slid out to a position where the point of the pin was flush with the down lock linkage surface as seen in enclosure (32). When I reached with my right arm to the micro-switch or upper left hydraulic connection, enclosure (13) (14) (15) (31) (32), my arm passed inside the red flag and under the protruding pin. Any further movement of my arm readily dislodged the pin completely, leaving the flagged pin draped across my right fore arm.

With my left leg in position underneath the down lock linkage, similar to the position depicted in enclosure (32), I reached for the hydraulic line top connection, enclosure (15), which the party was to secure, and as a result raised the down lock linkage with my thigh. The lifting of the down lock linkage out of the lock position required no intentional effort on my part. The process of repositioning my body in any way caused sufficient force to be applied to the down lock linkage to lift it out of the overcenter position, which in turn would have allowed the nose wheel to collapse if the aircraft had not been supported by jacks.

On the same occasion photographs and measurements were made of the ground lock safety pin in use at the time of the accident and a regulation safety pin as verified by the VC54 aircraft Handbook of Maintenance Instruction. Enclosures (18) (35) (36) (37).

(b) (6)

Witnessed:

(b) (6)

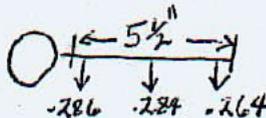
ENCLOSURE 1

5 February 1969

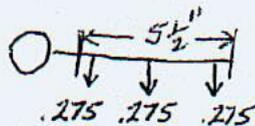
Statement of (b) (6), AMEL, (b) (6), USN  
assigned to the Aircraft Maintenance Hydraulic Shop of the  
U. S. Naval Air Facility, Naples, Italy. I did observe  
the following on 5 February, 1969.

On the 5 of February I measured the safety pin and holes for the nose  
wheel down lock of VC-54Q BUNO 050878. Measurements were also made  
of the regulation safety pin from Airforce C-54 BUNO 49099. The  
following measurements were observed. All measurements are in inches.  
Outer hole diameters on over center lock were .312 to .328, center  
hole diameter was .297. Drill hits were used to measure inside  
diameters.

Pin from aircraft 050878  
measured as follows:



Pin from aircraft 49099  
measured as follows:



I have read the above statement consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)

(b) (6) LCDR, USN

ENCLOSURE 1.

4 February 1969

Statement of PH1 (b) (6), USN, (b) (6), assigned as Petty Officer in Charge of the Photo Lab of the U.S. Naval Air Facility, Naples, Italy. I did observe the following on 4 February 1969.

I was the first person into the cockpit of VC-54, BU0 50878 after the accident at 1253 hours on 4 February 1969 in which the nose wheel collapsed, pinning AMSAN G. D. HOLLAND, USN, B33 52 91 into the wheel well.

Upon reaching the cockpit, PH3 (b) (6) USN, (b) (6), and I both took pictures of the landing gear handle, which was in the down and lock position with a safety latch on it. Reference picture Xa0 3173-2-69.

I have read the above statement, consisting of this (1) page and it is true to the best of my knowledge and belief.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)  
(b) (6), LCDR, USN

4 February 1969

Statement of (b) (6), AMSC, (b) (6), USN,  
assigned as Operational Maintenance Division Chief Petty Officer in  
charge of the Airframes Shop of the U. S. Naval Air Facility, Naples, Italy.

Gary D. HOLLAND, AMSAN, B33 52 91, USN second to AMHAN (b) (6),  
AMHAN, (b) (6), USN was my hardest working and most promising airman in  
the work center. I had tried to give them as much on the job cross  
training as I could. HOLLAND caught on to all jobs quickly and was a  
very hard and aggressive worker.

As to his safety habits, as noted by other Petty Officers in the work  
center and myself; they were not much different from any of the other  
men. He had left cotter pins out of some castle nuts on a job once  
and had to be told twice to properly install them. He had to be  
told on several occasions to wear a respirator while vacu-blasting, due  
to the danger of inhaling glass beads. He was grinding aluminium  
on the grinding wheel once and I told him of the danger of it  
exploding and not to do it.

Any job that he worked on he seemed to give his full attention to it  
and worked hard until it was completed.

I have read the above statement consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)

Witnessed:

(b) (6)  
(b) (6) LCDR, USN

ENCLOSURE 2.1

U. S. NAVAL AIR FACILITY  
FLEET POST OFFICE  
NEW YORK 09520

NAF NAPLES:ADP:DK:mm  
1000  
11 February 1969

From: Personnel Officer, U. S. Naval Air Facility, Naples, Italy  
To: Whom It May Concern

Subj: AMSAN Gary Doyle HOLLAND, USN, B33 52 91 (Deceased)

1. The below listed information is certified in case of the subject member.

a. He reported aboard U. S. Naval Air Facility, Naples, Italy on 23 November 1968 for a normal tour of overseas shore duty.

b. On Tuesday, 4 February 1969, he was on board this command in a duty status.

c. AMSAN HOLLAND attended the following Navy schools:

(1) AFUN"P" SCHOOL; Course Length 2 weeks; Date Enrolled 8 July 1968; Date Completed 19 July 1968; Final Mark 90.00; Graduated.

(2) AMFU"A" SCHOOL; Course Length 4 weeks; Date Enrolled 22 July 1968; Date Completed 16 August 1968; Final Mark 90.88; Class Standing 21 in a class of 248; Graduated.

(3) AMS"A" SCHOOL; Course Length 9 weeks; Date Enrolled 19 August 1968; Date Completed 16 October 1968; Final Mark 80.70; Class Standing 15 in a class of 44; Graduated.

d. AMSAN HOLLAND completed the following Navy Training Courses:

(1) Navy Training Course for Airman

(2) Basic Military Requirements

(3) Enlisted Correspondence Course, Military Requirements PO 3 & 2.

e. He completed his Practical Factors for AMS3 on 13 January 1969.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6), LCDR, USN

ENCLOSURE 2

5 February 1969

Statement of (b) (6), LCDR, (b) (6)/1312, USN,  
assigned as Operations Maintenance Division Officer of  
the U. S. Naval Air Facility Naples, Italy.

AMSAN Gary D. HOLLAND, B33 52 91, USN, was in a duty status at  
the time of the ground accident involving C-54 BUNO 50878  
about 1245A 4 February 1969.

(b) (6)

LCDR

USN

Witnessed:

(b) (6)  
(b) (6), LCDR, USN

10 February 1969

Statement of (b) (6) TNAN, (b) (6) USN  
assigned to the Security Division of the U. S. Naval Air Facility,  
Naples, Italy.

I met Gary D. HOLLAND, AMSAN, B33 52 91, USN in the month of November 1969 when he checked in to this command (NAF Naples, Italy) and moved into the same cube where I was staying (BEQ 2 Cube 9m VR-24 side). I have observed him as a quite type of an individual, although once in a while he showed his jovial and exuberant nature, when he had consumed a glass of beer or wine. However he never drank excessively. We went to church together for sometime and shared each other's money when finances became a problem. We visited several places sight seeing. He liked picture taking as a hobby. I considered him to be a real good guy. He talked of things concerning his work, but very seldom complained. He had the potential of a good worker, I mean promptness, willingness, and punctuality.

So far as problems, family, girl or any kind of such personal things is concerned I didn't know of any such things to exist prior to the accident, because we always discussed things when matters like that arose. I knew Gary D. HOLLAND for a period of 2 months and within this period of time, Gary in his humble nature won the respect of his friends around him. Sure wish we could have more guys like him. This is my humble opinion concerning Gary D. HOLLAND.

I have read the above statement consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6)

LCDR, USN

ENCLOSURE 1

4 February 1969

Statement of ABHC (b) (6), USN, (b) (6), assigned as Petty Officer in Charge of the Operational Maintenance Transit Line Division of the U.S. Naval Air Facility, Naples Italy.

I have worked in the U.S. Naval Air Facility, Naples, Italy in transient line for two (2) years and estimate that 85 to 90% of the C118 and C54 aircraft both Navy and Air Force, that land here do not have the regulation safety pins, and those that do, do not have the safety clip to hold the pin in place.

I have read the above statement, consisting of this (1) page and it is true to the best of my knowledge and belief.

Witnessed:

(b) (6)

(b) (6), LCDR, USN

(b) (6)

(b) (6)

FR0333 VW RFB271

1) 7/11/69 01

PP RUFRSAD  
DE RUFRSAA 0450 0371240  
ZNY ZEEZ  
P/N 5612442 PFB 51  
1A UNCLAS F F T O  
1C RUCILWA/COMNAVAIRLANT  
INFO RUEBDDHA/NAVAIRSYSOCOMH0  
RUCILWA/NAVAIRSYSOCOMPLANT  
RUDOMEA/CFN/UCRAV/CF  
RURDKEE/NAVPLANTRFPD DOKRAN  
RUCADGA/COMDEAS/CF  
RUFRSAD/NAF NAPLES  
RUFRSAD/NAFKA NAPLES  
BT

OPS.....  
ADMIN....  
CDO.....  
AMD.....  
OJD.....  
FANRA....

CORRECTED COPY  
CORRECTS UNDERLINED PORTIONS OF TEXT  
CORRECTED PER RUFRSAA 0217 0372120  
LE/B

UNCLAS F F T O ----- 4710 P AND E REPORT VC-540 BUNO 050878

- A. AVIATION DAMAGE REPORT DATE: FEB 69 HOTEL
- B. CONFIDENTIAL/COMNAVAIRLANT/PLANT/ST 4710.0
- C. NAVALR-01-40NM-3
- D. NAVALR-01-40NM-4

1. PLANNER AND ESTIMATOR (PAE) INSPECTION OF DAMAGES CITED REF A CONDUCTED LAW REF B. REFER REF C ALL STATION NUMBERS AND REF D ALL PART NUMBERS. ACFT SERVING IN FIRST CYCLE, FOURTH PERIOD, TWENTY-FIRST MONTH. ACFT TOUR END DATE MAY 1969. TOTAL ACFT HOURS

PAGE TWO RUFRSAA 0450 UNCLAS F F T O  
11,700.0.

2. DAMAGES

A. STRUCTURAL IMPACT

- (1) SKIN, FROM STA F.S. 217.0 TO STA F.S. 276.0 AND UNDERLYING STRINGERS NUMBERS 23, 29, 30, 31, 32 AND 33 BUCKLED AND TORN.
- (2) FRAME, STA F.S. 217.0 CRACKED AND DENTED.
- (3) FRAME/TRANSVERSE BEAM, STA F.S. 233.0 BUCKLED AND CRACKED.
- (4) FRAME, STA F.S. 260.0 BUCKLED.
- (5) JAMB INSTL, FRONT LOWER CAPGO DOOR, P/N 5105181-501, BUCKLED AND DISTORTED.
- (6) FAIRING TAIL SKID TORN.
- (7) WEB, NOSE WHEEL WELL L/H SIDE, OLD CRACK STARTING AT LANDING GEAR TRUNNION STA F.S. 191.0 AND EXTENDS AFT TWO INCHES THEN PROPAGATES UPWARDS AT A 45 DEGREE ANGLE TO STA F.S. 111.0. VERTICAL WEB STIFFENER AT STA F.S. 106.0 BUCKLED. NO LOGBOOK ENTRY.
- (8) DOORS NOSE LANDING GEAR, BUCKLED ALONG LOWER EDGE AND GOUGED ALONG UPPER EDGE.
- (9) FOLDING STRIP, NOSE WHEEL WELL R/H SIDE, TORN IN CENTER.
- (10) CONTROL COLUMN, R/H WHEEL, LOOSE.

PAGE THREE RUFPSAA 8 UNCLAS F F T O

(1) FLAP, R/H UPPER AND LOWER SKIN BETWEEN WING STA 100.0 AND STA 140.0 UNSUITABLE TEMPORARLY REPAIR. LO LOGBOOK ENTRY.

B. CORROSION DAMAGE/DETERIORATION.

(1) TAIL SECTION INTERNAL SKIN, STRINGERS AND FRAMES, EXTENSIVE SURFACE CORROSION.

(2) FUSELAGE, BOTTOM SKIN AND ATTACHING HARDWARE, FITTINGS AND SURFACE CORROSION.

(3) FUSELAGE, TOP SKIN, SPOTTY SURFACE CORROSION.

(4) WINGS, FLAP WELLS/UNDERLYING STRINGERS, EXTENSIVE SURFACE CORROSION.

(5) WINGS INTERNAL, BULKHEADS, WEBS, UPPER/LOWER SKIN, EXTENSIVE CORROSION.

(6) RIB, R/H WING AT INBOARD FLAP ACTUATOR, EXFOLIATION AND SURFACE CORROSION.

(7) FORMER, INBOARD L/H FLAP ACTUATOR, HEAVY SURFACE CORROSION.

(8) CABLES, BOTH WHEEL WELLS, RUSTY.

5. REPAIR OF DAMAGE LISTED PARA 2A ABOVE BEYOND ORG/INT MAINT CAPABILITY. ACFT NOW FLYABLE AND TEMPORARY REPAIRS NOT FEASIBLE DUE AREA OF DAMAGE.

4. ESTIMATE 1843 M/H AND 36 WORK DAYS IN PROCESS TIME TO EFFECT

PAGE FOUR RUFPSAA 0433 UNCLAS F F T O

PERMANENT REPAIRS DAMAGE CITED PARA 2A ABOVE. ESTIMATE 400 M/H AND 17 ADDITIONAL WORK DAYS FOR REPAIR CORROSION DAMAGE CITED PARA 2B ABOVE.

5. UNDIR INTEND INDUCT ACFT INTO FAMRA NAPLES 7 JAN FOR REPAIR OF STRUCT AND CORROSION DAMAGE.

6. RELATED SUBJ: REQ ADVISE AVAILABILITY REPLACEMENT VC-54 AIRCRAFT FOR TEMPORARY USE COMISEASTFOR.

BT

0433

TOR/17352/06 FEB 69 WJ/RO/C

061544Z

NNNN

CERTIFIED TO BE A  
TRUE COPY

(b) (6)

ENCLOSURE 23

75

**RECORD OF PRACTICAL FACTORS**

NAVPER 1414/1(AM) (8-67)  
S/N-0105-402-9150

OMD

**INSTRUCTIONS**

**ACTIVE DUTY PERSONNEL**

- As proficiency in each practical factor listed here is demonstrated an entry is to be made in the DATE and INITIALS columns by the supervising officer.
- Waivers may be granted for specific qualifications in accordance with current BuPers Instructions.
  - If a man demonstrates proficiency in skills considered to be within the scope of his rating but not listed in this list of minimum qualifications, an appropriate entry should be made on this form in the spaces provided unless the information is entered elsewhere in the man's service record.
  - A copy of this form is to be held by the division officer or by the appropriate supervising officer of each man in pay grade E-1 through E-8.
  - Upon transfer of an enlisted man, the supervising officer's copy of the form is to be signed, inserted in the correspondence side of the enlisted service record, and forwarded.
  - As changes in the rating structure and major change in the Manual of Qualifications for Advancement in Rating, NAVPER 18068B, occur, new forms will be made available. Minor

changes in NAVPER 18068B should be recorded in existing forms in the spaces provided.

One copy of the printed form should be made available to each man for his personal record and guidance.

**USNR (INACTIVE DUTY) PERSONNEL**

- Reserve units will indicate the factors that cannot be completed at the Naval Reserve Training Activity by a check (✓) in the USNR column. It is essential that the checked factors for the pay grade for which in training be completed on active duty for training. Additional factors requested for higher pay grades may be completed as time permits.
- In "REMARKS" section on reverse of form, the ship, station, or unit providing training will enter explanatory notes concerning types of equipment used, extent, and frequency of training received, and similar data whenever appropriate.
- Ship or station supervising officer must sign form for period of active duty for training.

RATING		ABBREVIATION		NAME		SERVICE NUMBER			
AVIATION STRUCTURAL MECHANIC (Through change 2, NAVPER 18068B)		AM		Holland, Gary D.		B335291			
DATES OF COMPLETION OF PRACTICAL FACTORS CHECKOUT FOR RATE LEVEL				USNR (INACTIVE DUTY) PERSONNEL					
				RESERVE UNIT NO	LOCATION				
PRACTICAL FACTORS	RATES	USNR	COMPLETED		PRACTICAL FACTORS	RATES	USNR	COMPLETED	
			DATE	INITIALS				DATE	INITIALS
<b>MILITARY STANDARDS</b>					<b>Q. SMALL ARMS (Men only)—Continued</b>				
<b>B. INTERNATIONAL AGREEMENTS</b>					41. Relieve a watch, armed with pistol. (Men only.) (Groups X and XI personnel demonstrate aptitude in the military custom aspect only.)				
.81 Explain the general purpose of the Status of Forces Agreements concerning personnel of the Armed Forces in foreign countries.					E-4 1-7-69 WEB				
.91 Explain the usual provisions of the Status of Forces Agreements concerning personnel of the Armed Forces in foreign countries.					E-4 1-7-69 WEB				
<b>1. BOAT</b>					<b>U. SIGNALS</b>				
.51 Command a squad in close-order drill.					41 Recognize general use signal flags and pennants.				
E-4 1-6-69					E-4 1-6-69 OAB				
<b>2. UNIFORMS</b>					<b>V. WATCHSTANDING</b>				
.39 Identify the following U.S. naval officer designators:					41 Relieve a watch, armed with pistol. (Men only.) (Groups X and XI personnel demonstrate aptitude in the military custom aspect only.)				
a. Corps devices.					E-4 1-6-69 OAB				
<b>L. FIRST AID AND PERSONAL HYGIENE</b>					<b>Y. TRAINING</b>				
41 Transport an injured person by fireman's lift and tied-hands crawl. (Men only.)					.51 Prepare an indoctrination schedule for new personnel reporting for duty.				
E-4 1-6-69					E-5				
<b>O. NUCLEAR, BIOLOGICAL AND CHEMICAL (NBC) WARFARE</b>					.52 Select and organize appropriate subject matter and instruct by demonstration method.				
41 Act as a member of a monitoring team, other than monitor. (Men only.)					.61 Teach a group, observing the following steps in developing the lesson:				
E-4 1-6-69					a. Setting the objectives				
42 Use a self-reading pocket dosimeter.					b. Presenting the subject matter.				
E-4 1-6-69					c. Providing trainee application through practical work and drill.				
.51 Use radiac instruments and perform monitoring and surveying operations on surfaces exposed to chemical, biological, and radioactive agents. (Men only.)					d. Summarizing key points.				
E-6					e. Testing trainee achievement.				
.61 Supervise an NBC decontamination team and personnel decontamination facility, observing safety precautions. (Men only.)					.62 Prepare and administer a written test which includes essay, multiple choice, true-false, and comprehension type questions.				
E-6					E-6				
.71 Supervise an NBC monitoring team. (Men only.)					.63 Use the following training aids and devices:				
E-7					a. Training films, slides, and transparencies.				
.81 Describe procedures to be followed in preparation against attack as set forth in the Nuclear Warfare and Biological and Chemical Warfare defense bills. (Men only.)					b. Charts and posters.				
E-6					c. Models and mockups.				
					d. Demonstrators and trainers.				
					.64 Conduct instruction by each of the following methods, using subject matter appropriate to each method:				
					a. Lecture				
					E-6				
					b. Questions and guided discussion.				
					E-6				



## SIGNATURE OF SUPERVISING OFFICER

NAME	SHIP OR STATION	INCLUSIVE DATES
(b) (6) [redacted] MSgt	AMS A Mfs Professional ONLY	1 6 OCT 1968
(b) (6) [redacted] Capt	AMS A Mfs Professional ONLY	1 6 OCT 1968
(b) (6) [redacted] ADCS	NAF, NAPLES, ITALY	1-13-69
(b) (6) [redacted] Ltjg	NAF, NAPLES, ITALY	1-15-69

CERTIFIED TO A

SERIES COPY

(b) (6)

HT USN

ENCLOSURE 26

0704 DEATH REPORT FORM front

0704

DEATH REPORT

THIS FORM IS TO BE USED ONLY TO REPORT CERTAIN DEATHS AS SET FORTH IN CHAPTER VIII, JAG MANUAL. SUBMIT TYPEWRITTEN ORIGINAL TO THE JUDGE ADVOCATE GENERAL VIA OFFICER EXERCISING GCM AUTHORITY.

NAVJAG 5800/18 (5-58)

REPORTS SYMBOL: JAG 5800-7

FROM: (Name of Reporting Command)  
 U. S. Naval Hospital, Naples, Italy  
 FPO New York 09521

VIA: (Officer Exercising GCM Authority)  
 CO, U.S. NavSuppAct, Naples

TO: Judge Advocate General  
 Navy Department  
 Washington, D.C. 20370

COPY TO: (Individual's Own Command if Report is Made by Another Authority)

PART I (BLOCKS 1 THROUGH 12) TO BE COMPLETED BY MEDICAL OFFICER

1. NAME: HOLLAND, Gary Doyle

2. SERVICE NUMBER: B33 52 91

3. GRADE: AN

4. BRANCH OF SERVICE: U. S. Navy

5a. DATE AND PLACE OF INCIDENT CAUSING DEATH: 4FEB69 NavAirFac, Naples, Italy

5b. DATE AND TIME OF DEATH: February 5, 1969 1120

6. FIRST SEEN BY MEDICAL OFFICER: DATE 4FEB1969 TIME 1230 PLACE U.S. NavHosp FPO NY 09521

7a. DIAGNOSIS, IF NOT DECEASED WHEN FIRST SEEN: Multiple Contusions of the Head and Chest

7b. APPARENT CAUSE OF DEATH, IF DECEASED WHEN FIRST SEEN: Alive

8. CONDITION OF INDIVIDUAL AT TIME OF EXAMINATION, IF MADE

a. UNDER INFLUENCE OF:  ALCOHOL  BARBITURATES  NARCOTICS  OTHER (Specify)

b.  NOT UNDER INFLUENCE OF ANY LISTED IN ITEM 8a.  UNABLE TO DETERMINE DUE TO PHYSICAL CONDITION

9. BASIS FOR OPINION IN 8a OR 8b ABOVE

ODOR OF ALCOHOL	TRUCULENT	UNCOORDINATED
STAGGERING	UNSTEADY	HICCOUGHING
SEMICONSIOUS	INCOHERENT	<input checked="" type="checkbox"/> NORMAL

10. BLOOD SPECIMEN FOR ALCOHOL DETERMINATION

WAS TAKEN	<input checked="" type="checkbox"/> WAS NOT TAKEN	HOUR TAKEN	TYPE OF TEST	RESULT
-----------	---	------------	--------------	--------

11. ANY OTHER TESTS (Specify): Not Applicable

10. ALLEGED CIRCUMSTANCES INITIALLY REPORTED AND SOURCE OF INFORMATION

The nose wheel strut failed and collapsed while AN HOLLAND was working in the nose compartment of a VC-54S aircraft, thus pinning him to the sides and top or back of the nose compartment.

11. WAS AN AUTOPSY CONDUCTED  YES  NO

(b) (6) EACH COPY OF AUTOPSY PROTOCOL

(b) (6) MEDICAL OFFICER LCDR MC USN

(b) (6)

NOTE: THERE ARE NO BLOCKS 13 THROUGH 16

2-12-69

7-4  
 Change 21

ENCLOSURE

Standard Form 603  
Rev. Feb. 1961  
Promulgated  
By Bureau of the Budget  
Circular A-52

CLINICAL RECORD		AUTOPSY PROTOCOL			
DATE AND HOUR DIED	A. M.	DATE AND HOUR AUTOPSY PERFORMED	A. M.	CHECK ONE	
5 FEB. 69	1120	6 FEB 69	1145	<input checked="" type="checkbox"/>	<input type="checkbox"/>
PROSECTOR		ASSISTANT		FULL AUTOPSY	HEAD ONLY TRUNK ONLY
DR. (b) (6)		HMC (b) (6)	USN	XXXXXXX	
CLINICAL DIAGNOSES (Including operative)					

1. Crush injury to the chest.
2. Brain anoxia.

PATHOLOGICAL DIAGNOSES

1. Anoxia of the brain. ( See attached autopsy report )

CERTIFIED TO BE A  
TRUE COPY

(b) (6)

RTUSN

APPROVED SIGNATURE					
(b) (6)	CDR MC USN	ACTING			
MILITARY ORGANIZATION (When required)	AGE	SEX	RACE	IDENTIFICATION NO.	AUTOPSY NO.
U. S. NAVAL HOSPITAL	20	MALE	CAUC	B33 52 91	
FPO, N. Y. 09521	PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME		REGISTER NO.	WARD NO.	
	HOLLAND, GARY DOYLE		290020		
	U. S. NAVAL HOSP.				
	FPO, NY 09521				

ENCLOSURE 4

Prof. (b) (6) M. D.

Medico - Legal Officer

N A P O L I

209/G, Via Scarlati 80127 - Tel. 374.286 - 370.548

University Medico - Legal Institute

5, Via Luciano Armani 80138 - Tel. 341.280

U. S. Naval Hospital

Via Scassone (Agnano) 80125 - Tel. 302.047 - Ext. 233

Naples, 7 February 1969

Report of autopsy performed on the corpse of HOLLAND, Gary D., AN USN B33 52 91, at the U.S. Naval Hospital, Naples, on 6 February 1969.

Autopsy commenced at 1145 and terminated at 1300.

External examination of the body showed it was that of a male, caucasian, approximately 20 years old, 68 $\frac{1}{4}$ " height. One scar, approximately 2 $\frac{1}{2}$ " on anterior left elbow; two scars, approximately 2 $\frac{1}{2}$ " each on right knee. Laceration, 1", on right jaw; laceration, complete, right index; laceration, 3", lateral surface of middle finger. Abrasions were also noticed on: left forearm, left thigh, left knee. Slight scratches on left thigh were also noticed. Surgical wounds: left anterior chest for cardiac massage; xiphoid-umbilical laparotomy; vein preparation left ankle. Incision for chest tube on left.

Head: Nothing worthy of note to the scalp, skull vault bones were intact. Nothing worthy of note to dura. Soft meninges were intensely injected. Signs of edema in the cerebral white and gray substance. Basilar bones were intact.

Neck: Blood extravasations were noticed in muscles of both lateral regions. In particular contusions were noticed adjacent to the bifurcation of carotids. Nothing else worthy of note to other neck formations.

Thorax: A small amount of cloth blood was noticed in left pleural cavity. Lungs were normal in form, volume was slightly augmented, consistency was fairly augmented; yellowish foam came out from large bronchi; a large amount of yellowish foam mixed with foamy blood came out spontaneously and much more under pressure from cut surfaces. Heart was normal in form, volume was proportioned to the body; nothing worthy of note to myocardium and valve apparatus; cavities were full with cloth blood. Some small arteriosclerotic inscriptions were noticed to the aorta. Nothing worthy of note to pulmonary.

Abdomen: Cavity organs were in situ. Stomach was partially extended due to the presence of food in early digestion process (corn and others). Soft and large intestine contained fluid stools. Liver was normal in form, volume was in proportion with the body; signs of hyperemia on cut surfaces. Gall bladder was full with fluid bile. Nothing worthy of note to pancreas and adrenals. Spleen was normal in form, volume was proportioned to the body; nothing worthy of note on cut surface. Kidneys were normal in form, volume was proportioned to the body; capsules unfolded well; signs of hyperemia on cut surfaces. Bladder was empty. Nothing worthy of note to testicles and penis (not circumcised).

Fracture of right index was noticed.

X-ray examinations showed the fracture of left jaw close to the angle.

Conclusion: Presumably the cause of death, according to the statements contained in the NAVMED Form N and the autopsy results, could be identified in a lack of oxygen to brain. Brain specimen forwarded to AFIP, Department of Forensic Medicine for additional tests. DD-892 and FD-893 enclosed.

CERTIFIED TO BE A  
TRUE COPY

(b) (6)

(b) (6)

(b) (6)

ENCLOSURE 2

CERTIFICATE OF DEATH  
 NAVMED N (REV. 4-58) FRONT

See MANNEE DEPT. for instructions regarding  
 number of copies and submission.

FROM (Ship or Station) U. S. Naval Hospital, Naples, Italy FPO New York 0952 IF UNIDENTIFIED INDICATE BY USING "X" AND CONSECUTIVE NUMBER HERE

1. NAME HOLLAND, Gary Doyle

2. SEX  MALE  FEMALE

3. RACE  CAUCASIAN  NEGROID  OTHER (Specify)

4. STATUS  REGULAR ACTIVE  RESERVE ACTIVE  RETIRED  DEPENDENT  VAP  OTHER (Specify)

5. LENGTH OF SERVICE (Years and months) 10 mos 28 days

6. AVIATION  YES  NO

7. FILE OR SERVICE NO. B33 52 91

8. RANK/RATE AN

9. CORPS

10. BRANCH OF SERVICE USN

11. PLACE OF BIRTH (City and State or Country) (b) (6) Florida

12. DATE OF BIRTH (Month, day and year) December 22, 1948

13. AGE (Years, months) (Days, if under 1 year) 20 Years 01 Months

14. RELIGION P

15. COLOR OF EYES Blue

16. COLOR OF HAIR Brown

17. COMPLEXION Ruddy

18. HEIGHT 68 1/2"

19. WEIGHT 144 Pounds

20. MARKS AND SCARS (Noted in health record)  
Scar, 4" Right Knee

21. FINGERPRINT - STATE WHICH FINGER (Right index preferred)  
  
Right Index Finger

22. NEXT OF KIN OR FRIEND (Relation, name, address)  
(Mother) (b) (6)  
(b) (6)

23. ADMITTED TO SICK LIST FROM (If on active duty, last duty station before current admission to sick list)  
U. S. Naval Air Facility, Naples, Italy FPO New York 09520

24. DATE ADMITTED TO SICK LIST (Month, day, year)  
February 4, 1969

25. PLACE OF DEATH  
U. S. Naval Hospital, Naples, Italy FPO New York 09521

26. TIME OF DEATH (Month, day, year, hour)  
February 5, 1969 1120

27. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
(a) Cerebral Anoxia

II. ANTECEDENT CAUSES. (Morbid conditions, if any giving rise to above cause (a), stating the underlying cause last)  
DUE TO (b) Crush Injury of the Chest

III. OTHER SIGNIFICANT CONDITIONS. (Conditions contributing to death but not related to the disease or condition causing death.)  
Bilateral Aspiration

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
21 Hours 30 Min

28. DO NOT WRITE IN THIS SPACE

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80

29. NAME

HOLLAND, Gary Doyle AN/USN B33 52 91

30. SUMMARY OF FACTS RELATING TO DEATH:

This Active Duty AN/USN reportedly was crushed between the nose and front wheel of an airplane on the afternoon of 4 February 1969. Apparently it required 12-15 minutes to extract him. On arrival at the U. S. Naval Hospital, Naples, Italy at about 1230 on 4 February 1969, he was cyanotic and had no cardiac action or respirations. During immediate endotracheal intubation massive bilateral pulmonary aspiration was evident. The heart action was restored by open cardiac massage and intra cardiac epinephrine. The patient remained shocky and an abdominal exploration revealed a massively dilated stomach with no other injury. He regained spontaneous respiration for about 6 hours, then stopped and required mechanical respiration. His vital signs then slowly deteriorated and expired at 1120, 5 February 1969. It was felt that the most critical injury was Cerebral Anoxia sustained at the time of his initial injury.

An autopsy has been performed. Findings will be forwarded under separate cover.

31. DISPOSITION OF REMAINS

Prepared and encased at U. S. Naval Hospital, Naples, Italy for further transfer to a civilian funeral home in CONUS pending instructions from Next of Kin.

32.

DATE SIGNED

2-7-69

SIGNATURE

(b) (6)

(Medical Officer)

LCDR

(MC) USN

(Rank)

33.

APPROVED: COURT OF INQUIRY OR BOARD OF INVESTIGATION

WILL

BE HELD

DATE SIGNED

7 FEB 1969

SIGNATURE

(b) (6)

(b) (6)

CAPT MC

USN

(Commanding Off)

(Rank)

NAVAL MESSAGE

NAVY DEPARTMENT

PRIORITY  
P 051502Z FEB 69  
FM NAVHOSP NAPLES

**EFTO**

TO SECNAV

INFO CHNAVPERS  
BUMED  
CINCUSNAVEUR  
COMFAIRMED  
COMSIX  
NAF NAPLES  
NAVSUPACT NAPLES  
NAVFINCEN CLEVELANT OHIO

UNCLAS E F T O

PERSONNEL CASUALTY REPORT  
A. BUPERSMAN ART C-9801

1. IAW REF A, FOL INFO IS SUBMITTED:

ALPHA: GARY D. HOLLAND, AN/USN, 833 52 91

BRAVO: ~~ACTIVE DUTY~~

CHARLIE: DECEASED - DEATH RESULTED FROM INJURIES SUSTAINED WHILE WORKING ON VC-54S AIRCRAFT

DELTA: 5 FEB 1969 - 1120 - U.S. NAVHOSP, NAPLES, ITALY

CIRCUMSTANCES: DIED OF INJURIES SUSTAINED WHEN NOSE WHEEL STRUT OF A/C HE WAS WORKING ON FAILED AND COLLAPSED, THUS PINNING HIM TO THE SIDES AND TOP OR BACK OF NOSE COMPARTMENT.

CAUSE: CERBRAL ANOXIA DUE TO CRUSHING INJURY OF CHEST.

ECHO: REMAINS HELD AT NAVHOSP NAPLES ITALY PENDING

INSTRUCTIONS FROM NOX

FOXTROT: (b) (6)

FLORIDA

GOLF: NOK HAS NOT BEEN OFFICIALLY NOTIFIED

HOTEL: IN LINE OF DUTY - NOT DUE TO OWN MISCONDUCT

INDIA: NAVPERS 601-2 VERIFIED ON 25 NOV 68.

JULIETT: (1) (b) (6) (MOTHER)

(b) (6)

(2) REQ COMSIX DISIGNATE ACTY TO PAY DEATH GRATUITY

(3) (b) (6) (MOTHER)

MED(2)/PERS(1) . . .ACT

09B2(2) 10(5) 007(2) FP(3) BFR(1) JAG(5) NAVREL(3) +

04841A  
028

CONTROL NO.	PAGE	OF	PAGE	TIME OF RECEIPT	DATE TIME GROUP
C07468/1/SC/	1		2	05/1714Z	051502Z FEB-69

1A

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK, NEW YORK

09520

4 FEBRUARY 1969  
UNCLASSIFIED

ZAD-3169 -2-69

AX5

VC-54 AIRCRAFT BUONO 50878 OF COMMIDEAIR FORCE, NOSE WHEEL  
COLLAPSED, PANNING, AMSAN G.D. HOLLAND, B32 54 51, USN INSIDE  
THE WHEELWELL. EMERGENCY CREW REMOVING HIM.  
\*OFFICIAL U.S. NAVY PHOTOGRAPHY, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED\*

SI:

 (b) (6)

PH3 USN



011:WB:br  
5830  
Ser 187  
26 FEB 1969

SECOND ENDORSEMENT on LCDR (b) (6) USN, (b) (6) 1310 investigation report of 20 February 1969

From: Commander, Fleet Air Mediterranean/Commander, Antisubmarine Warfare Force, U. S. Sixth Fleet  
To: Judge Advocate General

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft Bureau Number 50878 in Hangar 2, U. S. Naval Air Facility, Naples, Italy

1. Readdressed and forwarded.
2. The proceedings, findings of fact, opinions and recommendations of the investigating officer and the endorsement thereon are approved.

Copy to:  
NAF Naples

*E. C. Outlaw*  
E. C. OUTLAW



*Death  
Crushed  
5 Feb 69  
(inj 4 Feb 69)*

Veterans Administration  
Records Development Section  
03201  
Step 73  
*Hansen*

*77*

*1571-619*

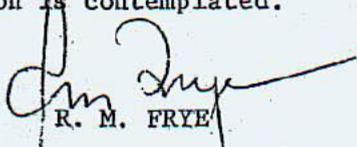
21 FEB 1969

FIRST ENDORSEMENT on LCDR (b) (6), USN, (b) (6)/1310 investigation report of 20 Feb 1969

From: Commanding Officer, U. S. Naval Air Facility, Naples, Italy  
To: Judge Advocate General  
Via: (1) Commander Fleet Air Mediterranean/Commander, Antisubmarine Warfare Force, U. S. Sixth Fleet  
(2) Commander in Chief, U. S. Naval Forces Europe

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft Bureau Number 50878 in Hangar 2, U. S. Naval Air Facility, Naples, Italy

1. Readdressed and forwarded.
2. The proceedings, findings of fact, opinions and recommendations of the investigating officer in this case are approved.
3. The Commanding Officer, U. S. Naval Air Facility, Naples has taken the following action toward implementation of the recommendations of the Investigating Officer:
  - a. By endorsement to this command's Aircraft Accident Board investigation of subject incident, the Naval Safety Center is requested to publicize to all C-54 aircraft operators (U. S. Navy and U. S. Air Force) the potential hazard of using a nose wheel ground lock which does not have a safety clip as prescribed in the C-54 Flight Manual and Handbook of Maintenance Instructions.
  - b. A Technical Information Maintenance Instruction (TIMI 2-69) has been promulgated within the Operations Maintenance Division of this command for the purpose of emphasizing to all Operations Maintenance Division personnel as well as to other maintenance personnel the importance of landing gear ground lock pins, including the exclusive use of regulation ground lock pins.
  - c. The Maintenance Training Program of this command is being revised to place more emphasis on all aspects of safety, with particular stress on the potential dangers involved in the maintenance of aircraft landing gear and wheel well accessories.
4. In concurrence with the Investigating Officer's recommendation that disciplinary action is not deemed necessary as a result of this investigation, no such action is contemplated.

  
R. M. FRYE

20 FEB 1969

From: LCDR (b) (6), USN, (b) (6)/1310  
To: Commanding Officer, U. S. Naval Air Facility, Naples, Italy

Subj: Investigation to inquire into the circumstances connected with the death of AMSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft Number 50878 in Hangar 2, U. S. Naval Air Facility, Naples, Italy

Ref: (a) JAG Manual

- Encl:
- (1) Appointing Order
  - (2) Statement of Witness: LT (b) (6), (b) (6), USNR
  - (3) Statement of Witness: HMC (b) (6), (b) (6), USN
  - (4) Statement of Witness: (b) (6), GS-9
  - (5) Statement of Witness: HM2 (b) (6), USN
  - (6) Statement of Witness: AMS3 (b) (6), USN
  - (7) Statement of Witness: ADJ2 (b) (6), USN
  - (8) Statement of Witness: ASC (b) (6), USN
  - (9) Statement of Witness: LCDR (b) (6)/1312, USN
  - (10) Statement of Witness: ADR1 (b) (6), USN
  - (11) Statement of Witness: LT (b) (6)/1310, USN
  - (12) Statement of Witness: AE1 (b) (6), USN
  - (13) Statement of Witness: AMSC (b) (6), USN
  - (14) Statement of Witness: AMH1 (b) (6), USN
  - (15) Statement of Witness: AMSAA (b) (6), USN
  - (16) Statement of Witness: ADR2 (b) (6), USN
  - (17) Statement of Witness: LCDR (b) (6)/1310, USN
  - (18) Statement of Witness: AMH1 (b) (6), USN
  - (19) Statement of Witness: PH1 (b) (6), USN
  - (20) Statement of Witness: Division Chief Petty Officer, AMSC (b) (6), USN
  - (21) Statement of Personnel Officer: CWO-2 (b) (6), (b) (6)/7822, USN
  - (22) Statement of Division Officer: LCDR (b) (6), (b) (6)/1312
  - (23) Statement of close friend: TNAN (b) (6), (b) (6), USN
  - (24) Statement of Operational Maintenance Transit Line Division Chief Petty Officer, ABHC (b) (6), USN
  - (25) Certified Copy of: Planner and Estimator report of damages to VC54Q BuNo 50878
  - (26) Certified Copy of: Record of practical factors of AMSAN Gary D. HOLLAND, B33 52 91, USN
  - (27) Death Report Form: NAVJAG 5800/16 (5-68)
  - (28) Certified Copy of Autopsy Report: Standard Form 503
  - (29) Certificate of Death: Form NAVMED N (Rev 4-58)
  - (30) Photograph: Accident Scene (aircraft in nose down position)

- (31) Photograph: Accident Scene (aircraft nose wheel well, position of ground lock safety pin)
- (32) Photograph: Aircraft Nose Wheel Well (simulated position of AMSAN Gary D. HOLLAND, B33 52 91, USN at the time of the accident)
- (33) Photograph: Aircraft Nose Wheel Strut (lower clamp power steering hydraulic lines)
- (34) Photograph: Aircraft Cockpit Compartment (landing gear handle selector)
- (35) Photograph: Ground Lock Safety Pin (in use at time of accident)
- (36) Photograph: Regulation Ground Lock Safety Pin
- (37) Photograph: Regulation Ground Lock Safety Pin (with safety clip installed)
- (38) Photograph: Damage to Aircraft (right forward fuselage)
- (39) Photograph: Damage to Electric Power Unit
- (40) Photograph: Damage to Aircraft (number (2) engine propeller)
- (41) Photograph: Damage to Aircraft (number (3) engine propeller)
- (42) Photograph: Aircraft Nose Wheel Well (down lock linkage micro switch)

#### PRELIMINARY STATEMENT

1. In accordance with reference (a) and as directed by enclosure (1) on 4 February 1969 I was appointed as investigating officer for subject accident. I was advised on procedure by Acting Legal Officer, LT (b) (6) /6602, USN, Assistant Administrative Officer of the U. S. Naval Air Facility, Naples, Italy who is not a lawyer in the sense of Article 27, UCMJ. I began the investigation at once.
2. During the course of the investigation legal advice was obtained from LTJG (b) (6) /1105, USNR assigned as Legal Officer of the U. S. Naval Air Facility, Naples, Italy, who is a lawyer in the sense of Article 27B(1), UCMJ.
3. The investigation was conducted in an unbiased and objective manner. No difficulties of note were encountered in compilation of evidence required for subject investigation other than mentioned below.
4. Medical information in Death Report, Form NAV/JAG 5800/16 (5-58), front line 6, Enclosure (27), and Certificate of Death, NAVMED N(Rev 4-58), back, paragraph 30, Enclosure (29), indicate that the time of first examination by a Medical Officer was about 1230, 4 February 1969. The investigation has revealed that the correct time of first examination was approximately 1330 vice 1230. This information has been brought to the attention of the originators of the above reports. The JAG report is forwarded with original medical reports to avoid undue delay.

FINDINGS OF FACT

1. That Gary Doyle HOLLAND, AMSAN, B33 52 91, USN, assigned to the Operations Maintenance Division Airframes Shop of the U. S. Naval Air Facility, Naples, Italy, was fatally injured at approximately 1248 local time on 4 February 1969. Enclosures (2), (27), (28), (29).
2. That the fatal injuries were received in the nose wheel collapse of U. S. Navy aircraft VC 54Q BuNo 50878 located in hangar No. 2, NAF Naples at the time of subject accident. Enclosures (27), (28), (29).
3. That immediate action was taken to free HOLLAND by placing men in the tail section and lifting the nose with a 20,000 lb forklift secured to nylon tow straps placed around the fuselage. Enclosures (2), (3), (4), (5), (8), (12), (30).
4. That HOLLAND was removed from the nose wheel well in 12-15 minutes and immediately administered mouth-to-mouth resuscitation and external heart massage by medical corpsmen for approximately ten (10) minutes prior to and five (5) minutes during the helo lift to the U. S. Naval Hospital, Naples, Italy, where open heart massage was immediately performed. Enclosures (3), (5), (9), (10), (11), (29).
5. That HOLLAND succumbed at 1120 on 5 February due to crush injuries to the chest and brain anoxia. Enclosures (27), (28), (29).
6. That due to the accident, aircraft VC54Q BuNo 50878 received substantial damage to the fuselage, nose wheel well doors and number (2) and (3) engine propellers. Enclosures (25), (30), (38), (39), (40), (41).
7. That HOLLAND was in a duty status at the time of the subject accident. Enclosures (21), (22).
8. That HOLLAND was assigned by (b) (6) AMH1, (b) (6) USN the task of securing mounting clamps for the nose wheel steering hydraulic lines and tightening the bolts which hold the down micro switch to the downlock linkage approximately 50 minutes before the subject accident occurred. Enclosures (14), (33), (42).
9. That at the time of the accident HOLLAND was working alone in the nose wheel well, however, had shortly before received assistance from (b) (6) AMSAA, (b) (6) USN, in securing the lower clamp for the nose wheel steering hydraulic lines. Enclosures (15), (33).
10. That HOLLAND had just entered the nose wheel well moments before the nose wheel collapsed. Enclosure (15).

11. That the ground lock safety pin was noted by two witnesses to be inserted in the down lock linkage two (2) to three (3) hours prior to the subject accident. Enclosures (14), (16), (42).
12. That the ground lock safety pin was noted by one (1) witness to be inserted from the left to the right side. Enclosures (16), (31).
13. That the ground lock safety pin in use was non-regulation, fit very loosely and could be inserted from either direction. Enclosures (17), (18), (35), (36), (37).
14. That this same ground lock safety pin had been used on the aircraft at least since 1 October 1968. Enclosure (16).
15. That at the time of the accident two (2) men were working on the number one (1) engine, and two (2) men were working in the admiral's compartment. Enclosures (3), (7), (16).
16. That the nose wheel collapsed slowly and the fall was broken by the starboard side of the fuselage contacting an electric power unit and the number (2) and (3) engine propellers contacting the hangar deck; which prevented the complete retraction of the nose wheel and much more severe crushing of the victim. Enclosures (6), (30), (38), (39), (40), (41).
17. That the gear handle selector was in the down and latched position when the cockpit was entered after the subject accident. Enclosures (19), (34).
18. That the aircraft was not on jacks at the time of subject accident. Enclosures (6), (14).
19. That installation of a new nose strut on the aircraft was completed on 1 February 1969, at which time the landing gear was considered to be structurally sound and stable and supporting jacks were removed to facilitate easy movement in event of a hangar fire. Enclosures (13), (14).
20. That the work in progress on the aircraft (securing accessory clamps and micro switch) by normal maintenance standards, did not require it to be supported by jacks. Enclosures (13), (14).
21. That the investigating officer readily dislodged the ground lock safety pin completely (with no intentional effort) by entering the nose wheel well and simulating the assigned work of HOLLAND. Enclosures (13), (14), (15), (17), (32).
22. That the down lock linkage when tested by the investigating officer could be lifted (unlocked) with virtually no effort when pressure was applied as described and depicted. Enclosures (17), (32).

23. That HOLLAND had recently assisted AMH1 (b) (6) in the removal and installation of the nose gear strut of subject aircraft. Enclosures (13), (14).
24. That HOLLAND was a recent graduate of the following formal schools: Aviation Fundamentals "P" School, Aviation Maintenance Fundamentals "A" School, and Aviation Metalsmith "A" School. Enclosure (21).
25. That HOLLAND had approximately two (2) months of practical experience in the Operational Maintenance Division Airframes Shop and completed his practical factors for advancement to AMS3 on 13 January 1969, which verifies demonstrated proficiency in observing safety precautions applicable to aviation structural work, including aircraft landing gear. Enclosures (21), (26).
26. That HOLLAND conscientiously worked hard at assigned tasks, however, was occasionally noted to disregard safety regulations. Enclosure (20).
27. That the interview by the investigating officer of HOLLAND's closest friend revealed no personal problems or temporary mental condition which could be instrumental in subject accident. Enclosure (23).

#### STATEMENT OF OPINION

1. That HOLLAND in the performance of his assigned duty accidentally retracted the nose wheel safety pin flush with the right side of the down lock linkage as he entered the right rear side of the nose wheel well. After getting into the position depicted in enclosure (32), so he could tighten the down-micro-switch mounting bolts, hydraulic connection, or clamp indicated in enclosure (31) as stated by enclosures (13), (14), (15), he reached under the red flagged safety pin or bumped it with his forearm and completely dislodged the pin. Upon seeing the pin dislodged he repositioned his body to re-insert the safety pin and in so doing he applied sufficient force with the thigh of his leg to break the lock mechanism of the down lock linkage, thus allowing the nose gear to collapse.
2. That HOLLAND's recent formal instruction, enclosures (21), (26), covering the basic operation of aircraft landing gear, the functions of safety pins and necessary precautions which should be taken when performing maintenance of this nature, qualified him to perform such work as was assigned without direct and immediate supervision.
3. That the accident would not have occurred if a regulation safety pin with safety clip installed, enclosure (37), had been in use and if the party had been more acutely aware of the potential danger involved when the safety pin was dislodged.
4. That based on enclosure (24), and the investigating officer's interview of numerous VC-54 aircraft ex-crewmembers including one of the previous COMIDEASTFOR pilots, it is a common Navy and Air Force procedure to use a non-regulation safety pin, in that, a safety clip is not installed. Considering that the pin in use is virtually identical to the regulation

pin, with the exception that there was no safety clip attached, it would not be expected that the crewmembers or shop maintenance personnel would have noted or questioned the suitability of the pin.

5. That the death of HOLLAND was not caused by the intent, fault, negligence or inefficiency of any person or persons in the Naval Service or connected therewith.

#### RECOMMENDATIONS

1. That appropriate action be taken to insure dissemination of all pertinent information of subject accident to all Navy and Air Force operators of subject type aircraft.

2. That appropriate action be initiated to insure that regulation ground lock safety pins are installed in all aircraft (transient included) prior to performance of any maintenance functions by Naval Air Facility personnel.

3. That appropriate action be initiated to insure current training procedures be modified to more strongly stress the potential danger involved in the maintenance of aircraft landing gear and wheel well accessories.

4. That disciplinary action is not deemed necessary as a result of this investigation.

(b) (6)

(b) (6)

DEPARTMENT OF THE NAVY  
U. S. Naval Air Facility  
FPO New York 09520

In reply refer:

NAF NAPLES: 5830

LE:RHB:mh

Ser 171

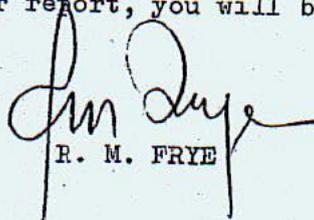
5 Feb 1969

From: Commanding Officer, U.S. Naval Air Facility, Naples, Italy  
To: Lieutenant Commander (b) (6) USN, (b) (6)/1310

Subj: Investigation to inquire into the circumstances connected with the death of ANSAN Gary D. HOLLAND, USN, B33 52 91, as a result of an accident on 4 February 1969 at approximately 1250 while working on a C-54 aircraft number 50878 in Hangar 2, U.S. Naval Air Facility, Naples, Italy

Ref: (a) Verbal order of 4 February 1969  
(b) JAG Manual

1. As directed by reference (a), and in accordance with reference (b), you were appointed to conduct an informal investigation on 4 February 1969, or as soon thereafter as practicable, for the purpose of inquiring into all the circumstances connected with subject accident.
2. You will conduct a thorough investigation into all the circumstances connected with the subject accident and report your findings of fact, opinions and recommendations as to the cause of subject accident, the resulting damage, the circumstances attending death of a member of the naval service, and responsibility for the accident, including any recommended administrative or disciplinary action.
3. You will be furnished the necessary reporters and clerical assistance for recording and transcribing the testimony of witnesses and assisting you in preparing the report of the results of your investigation. In preparing and submitting your report, you will be guided by the provisions of reference (b).

  
R. M. FRYE

ENCLOSURE 

4 February 1969

Statement of (b) (6), LT, USNR, (b) (6),  
assigned as co-pilot of COMIDEASTFOR Flag Aircraft VC54Q BUNO 50878.  
I did observe the following on 4 February, 1969.

At approximately 1248 (local) 4 February 1969 LCDR (b) (6)  
USNR, (b) (6)/1315 and I were standing just outside the NAF Naples  
hangar #2 and had been observing a USAF C-141 aircraft rolling out,  
after landing (above time verified by NAF Naples tower as landing  
time of the C-141). Out of the corner of my eye I noticed the tail  
of the COMIDEASTFOR flag aircraft, VC54Q BUNO 50878, raising up, and  
turning around to see the aircraft, realized that the nose gear had  
collapsed. The aircraft was settling onto the nose wheel as I  
turned around. I had just walked from the nose of the aircraft and  
had seen a man working up in the nose wheel well. I immediately ran  
to the nose of the aircraft to try to ascertain if the man was still  
in the wheel well. Many men converged at the nose of the aircraft  
and one of the man's feet could be seen up in the well. Approximately  
10 minutes later a fork lift arrived and after a sling had been  
placed under the aircraft, the nose was raised enough to extricate  
the man from the wheel well. I saw the nose gear safety pin with red  
flag still attached laying on the deck directly below the nose gear  
after the man had been removed. I did not see this pin fall from  
inside the wheel well. Artificial mouth-to-mouth resuscitation was  
begun by the corpsman as soon as the man was taken from the wheel  
well and placed on a stretcher, and continued until he was placed  
aboard a waiting helicopter.

I have read the above statement, consisting of this (1) page  
and it is true to the best of my knowledge and belief.

(b) (6)  
(b) (6)

Witnessed:

(b) (6)

(b) (6), LCDR, USN

ENCLOSURE <sup>2</sup>

4 February 1969

Statement of (b) (6), HMC, (b) (6), USN assigned as Chief Petty Officer in charge of the Medical Department of the U. S. Naval Air Facility, Naples, Italy. I did observe the following on 4 February 1969.

At approximately 1253 we were notified by telephone of an emergency in the U. S. Naval Air Facility hangar #2. (b) (6), HM2, (b) (6), USN, and I arrived at the scene with the ambulance at approximately 1255.

Upon arrival I crawled under the aircraft and attempted to communicate with the injured man and received no reply. HM2 (b) (6) and I tried to reach the man but there were no possibilities of reaching him either from above or below. It took the crew approximately 10 minutes to release the victim from the aircraft. Upon release I started to administer mouth-to-mouth resuscitation and HM2 (b) (6) was attempting closed heart massage. The patient was cyanotic and had ceased breathing as far as we could determine at the time. He also appeared to have had a cardiac arrest.

Captain (b) (6), (b) (6)/2200, USN(DC) with Lt. (b) (6), (b) (6)/2200, USNR(DC) relieved HM2 (b) (6) of the heart massage while (b) (6) tried to set up emergency oxygen. In the meanwhile a res-cu-air was brought to the scene and thus was placed into immediate use. After approximately 20 minutes of artificial respiration and external cardiac massage the patient was helo lifted to the U. S. Naval Hospital, Naples, Italy. Just prior to lift off he was given 0.5cc of 1:000 solution of epinephrine directly into the heart cavity, this was witnessed by Lt. (b) (6). Upon arrival at the hospital he was transported to surgery. The time of the helo arrival was approximately 5 minutes after helo lift off.

I have read the above statement, consisting of this (1) page and it is true to the best of my knowledge and belief.

(b) (6)

(b) (6)

Witnessed:

(b) (6)

(b) (6), LCDR, USN

ENCLOSURE 3

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK, NEW YORK

109520

XAD-3171 -2-69

4 FEBRUARY 1969

4X5

UNCLASSIFIED

VC 54 AIRCRAFT, BUONO 50878 of COMMIDEASTFORCE, NOSE WHEEL  
COLLAPSED, PINNING AMSAN G.D. HOLLAND, B33 52 91, USN, INSIDE  
WHEELWELL, NOSE GEAR AFTER SAFETY PIN WAS INSTALLED BY ONE OF  
THE MAINTENANCE MEN.

"OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED"

BY: (b) (6) [REDACTED] PPS GSN

NSA (b) (6)

OFFICIAL U.S. ARMY PROGRAM, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RECLASSIFIED

IN PAGE TO PROP ON NO 3 ENGINE OF VC 54 DUNO 50878 and

UNCLASSIFIED  
4 FEBRUARY 1969

XAD 1193-2-59

09520

U.S. NAVAL AIR FACILITY, NERLES, ITALY, FPO NEW YORK, NEW YORK

U.S. NAVAL AIR FACILITY, NAPLES ITALY, PO NEW YORK, NEW YORK  
09520  
YAD 3177-2-69  
2 1/2 x 2 1/2  
UNCLASSIFIED  
7 FEBRUARY 1969  
" U.S. NAVAL AIR FACILITY, NAPLES ITALY, PO NEW YORK, NEW YORK  
COLLAPSED, PINNING AMSNAN G.D. HOLLAND B33 52 91 USN INSIDE  
THE WHEELWELL. DAMAGE TO THE PROP AND THE HANGER FLOOR.  
" OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED  
BY: [REDACTED] (b) (6) USN.

U.S. NAVAL AIR FACILITY, NAPLES ITALY, FPO NEW YORK NE 1 YORK

09520

4 FEBRUARY 1969

UNCLASSIFIED

XAD 3179-2-69

2X x 2X

VC 54 AIRCRAFT BUNO 50873, OF CONFIDIST FORCE; NOSE WHEEL  
COLLAPSED, HITTING A SAN G. D. HOLLAND B33 52 91 USN INSIDE  
WHEEL WHEEL FEEL. AUX POWER UNIT DAMAGE WHEN PLANE TITLED  
FOR V. D.

OFFICIAL U.S. NAVY PHOTOGRAPH NOT FOR PUBLICATION UNLESS  
SPECIALLY RELEASED"

BY (S) [REDACTED] P. 3 USN

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, PRO NEW YORK, NEW YORK

09520

XAD 217-2-69

4 FEBRUARY 1969

UNCLASSIFIED

2X \* 2X

AC SA AIRCRAFT, PORT 50073 OF COMMANDER, NOSE WHEEL

COLLAPSED PILING AND AMBUSH ON HOLLAND 33 2 91, USN INSIDE

THE WHEEL - DAMAGED TO AIRCRAFT OF THE FORWARD CARGO

WHEEL, CAUSED BY POWER UNIT UNDER THE AIRCRAFT.

OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS

OFFICIALLY RELEASED

(b) (6) USN

U.S. NAVY AIR FACILITY, NAPLES ITALY, PRO NEW YORK NEW YORK

00520

ADM 0186-2-69

4 K 5

5 FEBRUARY 1969

UNCLASSIFIED

ROSE HULBURY SUFFY PIV FOR AIR FORCE VC-24 TYPE AIRCRAFT

WITH THE SUFFY LACK IN

OFFICIAL U.S. AIR FORCE, NOT FOR PUBLICATION UNLESS

OFFICIALLY REQUESTED

BY [REDACTED] (b) (6)

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK NEW YORK  
09520

XAD 3185-2-69

4 X 5

5 FEBRUARY 1969  
UNCLASSIFIED

USE WHEEL SAFETY PIN FROM U.S. AIR FORCE VC-54 TYPE  
AIRCRAFT WITH THE SAFETY LOCK OUT.  
" OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED"

NY [REDACTED] ph 3 JSC.

U.S. NAVAL AIR FACILITY, NAPLES ITALY, FPO, NEW YORK NEW YORK  
09520

XAD 3180-2-69

24 12M

MOSE WHEEL SAFETY PIN FROM VC 54 BUMO 50878.

4 FEBRUARY 1969  
UNCLASSIFIED

OFFICIAL U.S. NAVY

FOR PUBLICATION, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED"

BY (b) (6)

USN.

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK, NEW YORK  
09520

XAD-3173 -2-69  
4X5

4 FEBRUARY 1969  
UNCLASSIFIED

VC 54 AIRCRAFT, BUNO 50878 of COMMIDEASTFORCE, NOSE WHEEL  
COLLAPSED, PINNING, AMSAN G.D. HOLLAND, B33 52 91 USN, INSIDE  
THE WHEELWELL, LANDING GEAR HANDLE IN THE DOWN AND LOCK  
POSITION WITH A SAFETY LOCK ON IT.

" OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED"

BY: (b) (6) PH3 USN

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK, NEW YORK

XAD- 3172-2-69

09520

4 FEBRUARY 1969

4X5

UNCLASSIFIED

VC 54 AIRCRAFT, BUONO 50878 of COMINTDEASPRORCE, NOSE WHEEL  
COLLAPSED, PINNING AMSAN G.D. HOLLAND, B33 52 91, USN, INSIDE  
THE WHEELWELL, AREA AMSAN HOLLAND WAS WORKING ON.

" OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED"

BY: [REDACTED] PHX USN.

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK NEW YORK  
09520

XAD 3191-269

2 1/2 x 2 1/4

FEBRUARY 1969

UNCLASSIFIED

SHOWING THE POSITION ON THE DECK WHEN HE IS WORKING IN THE  
WHEELWELL OF A V-58.

" OFFICIAL U.S. NAVY PHOTOGRAPH NOT FOR PUBLICATION UNLESS  
OFFICIALLY REQUESTED

R. (b) (6) PHO 0511

U.S. NAVAL AIR FACILITY, NAPLES ITALY FPO NEW YORK, NEW YORK

XAD 3184-269  
4X5

09520

4 FEBRUARY 1969

UNCLASSIFIED

VC 54 AIRCRAFT, BUHO 50378, 02 COMIDEASTFORCE, NOSE WHEEL  
COLLAPSED, PINNING AIRMAN G.D. HOLLAND INSIDE THE WHEELWELL.  
LOOKING UP INTO THE WHEELWELL AT THE WIRING THAT HE WAS WORK-  
ING ON.

OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
SPECIALLY AUTHORIZED

BY (b) (6) [REDACTED] WFO DSC

U.S. NAVAL AIR FACILITY, NAPLES, ITALY, FPO NEW YORK, NEW YORK

09520

4 FEBRUARY 1969

UNCLASSIFIED

1AD-1169 -2-69

AX5

VC-54 AIRCRAFT BUHO 50878 OF COMNAVSTA/SPONSO, NORSF AHEAD  
COLLAPSED, PANNING, AMSAN G.D. HOLLAND, B59 52 21, USN INSIDE  
THE WRECKWELL. EMERGENCY CREW REMOVING HIM.  
"OFFICIAL U.S. NAVY PHOTOGRAPH, NOT FOR PUBLICATION UNLESS  
OFFICIALLY RELEASED"

FM3 USN

BT: (S)

(S)