



**DEPARTMENT OF THE NAVY**

COMMANDER STRIKE FIGHTER WING  
U.S. PACIFIC FLEET  
001 K ST BLDG 1 RM 121  
NAS LEMOORE CA 93245-5002

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Ser N00/258  
1 Nov 19

FIRST ENDORSEMENT on CDR (b) (3) (A), (b) (6) ltr of 8 Sep 19

From: Commander, Strike Fighter Wing, U.S. Pacific Fleet  
To: Commander, Naval Air Force, U.S. Pacific Fleet

Subj: COMMAND INVESTIGATION INTO THE CLASS A FLIGHT MISHAP ON 31 JULY 2019

Ref: (a) JAGINST 5800.7F CH-1

Encl: (1) Command Investigation into the Class A Flight Mishap of 18 Sep 19 w/ Enclosures

1. The Investigating Officer conducted a thorough and impartial investigation regarding the mishap that occurred on 31 July 2019 in Death Valley National Park. The mishap resulted in the death of LCDR Charles Z. Walker, USN, the complete loss of one F/A-18E assigned to Strike Fighter Squadron ONE FIVE ONE (VFA-151) at Naval Air Station Lemoore, and injuries to crash site bystanders that were French foreign nationals.
2. I concur with the facts, opinions, and recommendations contained therein.
3. I have directed that the findings of this investigation will be widely shared with all units under my cognizance to underscore the unforgiving and inherently dangerous nature of naval aviation, which requires the finest sense of judgment and control.
4. The point of contact for this matter is CDR (b) (3) (A), (b) (6) JAGC, USN, who can be reached at (b) (3) (A), (b) (6)

**(b) (3) (A), (b) (6)**

J. S. BATES

Copy to:  
COMCARSTRKGRU THREE

18 Sep 19

From: CDR (b) (3) (A), (b) (6) Investigating Officer  
To: Commander, Strike Fighter Wing, U.S. Pacific Fleet

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Ref: (a) JAGINST 5800.7F CH-1, Chapter II  
(b) CSFWP Standard Operating Procedures  
(c) VFA-151 SOP  
(d) CSFWP NAS Lemoore Inflight Guide (Mar 2016)

Encl: (1) CSFWP Appointing Order of 26 Aug 2019  
(2) Preliminary Inquiry of 15 Aug 2019  
(3) Copy of original VFA-151 flight schedule of 31 Jul 2019  
(4) Copy of smooth VFA-151 flight schedule of 31 Jul 2019  
(5) Copy of smooth VFA-151 flight schedule of 30 Jul 2019  
(6) R-2508 Complex Daily Brief Sheet of 31 Jul 2019  
(7) R-2508 Complex Daily Brief Sheet of 31 Jul 2019, Change I  
(8) R-2508 Complex Daily Brief Sheet of 31 Jul 2019, Change II  
(9) CSFWP Inflight Guide  
(10) R-2508 User's Brief  
(11) R-2508 User Handbook  
(12) CSFWPINST 3710.9I Core SOP  
(13) March, April, May, June, and Jul 2019 SHARP logbook reports for LT Charles Walker,  
IISN

**(b) (3) (A), (b) (6)**

(19) Naval Aviator Aviation Training Jacket (ATJ) Summary Card for LT Charles Walker, USN  
(20) NATOPS Evaluation Report for LT Charles Walker, USN  
(21) NATOPS Instrument Rating Request for LT Charles Walker, USN

**(b) (5)**

(24) Maps of flight overview and impact area

**(b) (5)**

(28) Flight profiles from NAVAIRSYSCOM review of 30 Jul 2019 flight data  
(29) MIST Infield Report  
(30) Voluntary statement of LT (b) (3) (A), (b) (6) USN  
(31) Voluntary statement of CDR Chad Heirigs, USN  
(32) Voluntary statement of LT (b) (3) (A), (b) (6) USN  
(33) Voluntary statement of LCDR (b) (3) (A), (b) (6) USN

(34) Statements to National Park Service from French national observer, with translation

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(39) Email correspondence summary of Mr. (b) (3) (A), (b) (6) NAVAIRSYSCOM Engineer

(40) Email conversation summary with CDR (b) (3) (A), (b) (6) USN

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(43) Aviation Maintenance Supply and Readiness Reporting (AMSRR) database report for VFA-151 31 Jul 2019

(44) Printout of maintenance status tracker for VFA-151 30 Jul 2019

(45) Historical weather for R-2508 on 31 Jul 2019

(b) (3) (A), (b) (6)

#### Preliminary Statement

1. Pursuant to enclosure (1) and in accordance with reference (a), I conducted a command investigation into the events and circumstances surrounding the Class A flight mishap that occurred on 31 July 2019 in Death Valley National Park. The mishap resulted in the death of LT Charles Walker, USN, the complete loss of one F/A-18E assigned to Strike Fighter Squadron ONE FIVE ONE (VFA-151) at Naval Air Station (NAS) Lemoore, and injuries to crash bystanders. All interview notes are attached in summary-form and available for your review. I consulted in the preparation and conduct of the investigation with the assigned legal advisor, LT (b) (3) (A), (b) (6) JAGC, USN. All reasonably available and relevant evidence was collected in compliance with the convening authority's directives. The purpose of the investigation was to find the cause of the mishap, assign fault, if any, and recommend appropriate command actions, including remedial safety and training actions.

2. The investigation found that at 0943 local time on 31 July 2019, an F/A-18E impacted the ground on the south side wall of Rainbow Canyon in Death Valley National Park, CA. The aircraft, BUNO 168471, was destroyed and the pilot, LT Charles Z. Walker, was killed. This investigation concludes that a failure to recognize a dangerous flight profile with respect to terrain proximity resulted in the loss of the aircraft and death of the pilot. The aircraft is believed to have entered a flight profile which was too fast and too low with respect to the surrounding terrain. The flight profile created conditions where the processing time and subsequent reaction time required of the pilot made it difficult for the aircraft to exit the canyon safely, as evidenced by the mishap result.

3. With very minor exceptions in memory recall, all voluntary statements collected are consistent with the above narrative of events. All statements were provided voluntarily and interviews include signed summaries of the interview. Naval Air Training and Operating Procedures (NATOPS) jackets and flight logbooks for the mishap pilot were reviewed by the investigating officer and are held by the aviation mishap board (AMB). All other applicable evidence is provided in the enclosures. Photographs and video are stored on removable media. Raw video footage from a GoPro video camera onboard the mishap wingman's aircraft contains classified content and is not included.

Findings of Fact

1. One F/A-18E aircraft, BUNO 168471 was destroyed during a flight mishap between 09:43:35 and 09:43:38 local time, 31 July 2019. [Encls. (1), (2), (26), (27), (30), (34)]
2. LT Charles Z. Walker, USN, was killed as a result of the mishap. [Encls. (1), (2), (26), (27), (30), (34), (35)]
3. LT Walker had flown 2049.6 military flight hours. LT Walker's 30/60/90 day summary was 5.1/38.3/59.8 flight hours respectively, with seven flights flown in the low level training environment within the last 90 days prior to the mishap. [Encl. (13)]
4. The mishap pilot was a designated Naval Aviator (1310) and was both NATOPS and instrument qualified in the F/A-18E/F Super Hornet at the time of the mishap. [Encls. (20), (21)]
5. The mishap pilot was fulfilling orders as the Training Officer to VFA-151, was a graduate of TOPGUN, and had a Strike Fighter Weapons and Tactics (SFWT) Level 4I qualification. [Encl. (31)]
6. The mishap pilot was medically qualified and aeronautically adapted for flight. [Encls. (22), (23)]
7. LT Walker was married with no children. He and his wife were married on 31 March 2018. At the time of the mishap, LT Walker's wife was living near Seattle, WA. [Encls. (17), (18), (30)]

Pre-Flight / Mission Planning

8. LT Walker mustered normally in VFA-151 spaces on 31 July 2019. Squadron personnel noted nothing unusual about LT Walker's behavior that morning or leading up to the mishap. [Encls. (14), (30), (32)]
9. LT Walker was designated as Mission Commander for the mishap flight. LT Walker briefed his wingman, LT (b) (3) (A), (b) (6) USN, for VFA-151 event one, a two-ship flight with the air traffic control call sign of Switch 11, in VFA-151 mission planning spaces at 0730 local time. [Encls. (3), (30), (32)]
10. The flight was scheduled to fly the VR-209 military training route as authorized/approved by CDR Chad Heirigs USN, Commanding Officer, VFA-151. The mission was changed to the R-2508 range training complex and the Sidewinder low level route due to weather in the vicinity of VR-209. [Encls. (3), (4), (6), (9)]
11. LT Walker briefed a plan to first execute low level training on points A through C and the Jedi transition along the Sidewinder low level route within the R-2508 range training complex, followed by air-to-surface training, followed by air-to-air training if time allowed. [Encls. (3), (4), (6), (30)]
12. LT Walker was current in the aircraft according to NATOPS and Commander, Strike Fighter Wing, U.S. Pacific Fleet (CSFWP) requirements. LT Walker was not Low Altitude Training (LAT) current. LT Walker had flown the day prior, 30 July 2019, in the LAT environment, but not for the minimum 10 minutes in the low altitude environment in the last 30 days. [Encls. (12), (13)]

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13. LT Walker's lack of currency in the LAT environment was addressed in the brief, whereby LT Walker assigned a minimum altitude (MINALT) of 500 feet above ground level (AGL) for himself, and cleared his wingman, LT Slater, to a MINALT of 200 feet AGL if desired, as LT Slater was LAT current. [Encls. (12), (13), (30)]

14. The flight brief lasted approximately 30 minutes and all pertinent and mandatory items were briefed. [Encls. (6), (30)]

15. LT Walker was considered to be the most LAT proficient pilot in the squadron, having flown seven times in the low level environment in the three months preceding the mishap. CDR Heirigs and LCDR (b) (3) (A), (b) (6) emphasized that the "low level" flight was likely a favorite mission of LT Walker and that he was very thorough in his preparation for the LAT mission. [Encls. (13), (30), (31), (33)]

16. The mishap aircraft was released safe-for-flight (SFF) by VFA-151 maintenance personnel with zero downing discrepancies with appropriate daily and turnaround inspections. [Encls. (41), (42), (43), (44)]

17. Aircraft 168471 was configured for the flight with a centerline external fuel tank, an ATFLIR, and 3 pylons (Station 6, 2, and 10). No internal or external ordnance, items, or other carriage devices were on the mishap aircraft. [Encls. (41), (42), (43), (44)]

#### Flight and Mishap

18. The mishap flight was scheduled for a 0915 local time launch. Actual launch occurred at approximately 0914. [Encls. (3), (4), (30)]

19. The mishap flight executed a takeoff on 32R at NAS Lemoore and flew the Hornet 5 stereo route, proceeding generally SW before entering R-2508 at point ROMOF. [Encls. (4), (11), (24), (30)]

20. Range R-2508 is located in the upper Mojave Desert of southern California, and includes airspace over Death Valley National Park. Father Crowley Overlook is within Death Valley National Park and is a popular viewing point for ground observers to watch aircraft transit the Sidewinder low level route. The terrain is uninhabited mountainous desert terrain. [Encls. (9), (10), (11), (24), (31), (34)]

21. The weather in R-2508 was as forecasted with clear skies and unrestricted visibility. At 0943 local time the sun was at 99.77 degrees azimuth and 43.92 degrees altitude. [Encls. (25), (26), (27), (45)]

22. Once established in R-2508 and over the vicinity of Lake Isabella, California, the flight conducted a G-awareness maneuver and took a lead-trail formation of 1.5 NM to 2.5 NM spacing. LT Walker was lead; LT (b) (3) (A), (b) (6) was trail. [Encls. (9), (10), (11), (30)]

23. During the descent to the briefed low altitudes from point A to point B, the flight verbalized completion of the low altitude checklist. [Encls. (9), (10), (11), (30)]

24. Throughout the low-level environment, the LT (b) (3) (A), (b) (6) maintained 1.5 to 3.5 NM in trail of the lead, LT Walker, and the flight maintained an airspeed between 450 to 600 knots calibrated airspeed (KCAS). [Encls. (26), (30)]

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25. The flight proceeded on the Sidewinder low level route from point C via the Jedi transition to the vicinity of point J. [Encls. (9), (10), (11), (30)]

26. The mishap aircraft entered Rainbow Canyon, commonly referred to as "Star Wars Canyon," from the west in a left turn, descending through 4,000 feet mean sea level (MSL), at approximately 550 KCAS, with afterburners staged, then rolled wings level in a slight descent. Then, approximately 3 seconds elapsed with no data or eyewitnesses. The mishap aircraft impacted the south side wall of Star Wars Canyon near the Father Crowley Overlook area, 46 nautical miles north of China Lake NAS, at Lat/Long: N 36.3545550 W 117.5456017 (N 36 21.2733 W 117 32.7361, 11SMA5104723412), elevation 4,102 feet MSL. The location is within Death Valley National Park and the R-2508 range training complex. [Encls. (10), (11), (24), (25), (26), (27), (30), (39)]

27. The mishap wingman did not see the mishap aircraft impact the ground. The wingman was in a hard right-hand pull at the time of impact and reversed left to roll wings level when he saw a huge ball of fire extending up in a column of fire and smoke. [Encls. (26), (30)]

28. The mishap wingman did not have the Cockpit Video Recording System (CVRS) on, or "tapes" on, during the time of impact. There is wingman video from a personal GoPro which shows the mishap aircraft explosion post-impact. [Encls. (26), (30)]

29. The mishap wingman attempted to hail the mishap pilot on the auxiliary frequency with no response. The wingman then transmitted on low level common frequency for all aircraft to remain clear of Star Wars Canyon. The wingman then coordinated SAR assets with Joshua Approach on R-2508 area common frequency. [Encl. (30)]

30. The mishap wingman remained overhead the impact location between 10,000 and 15,500 feet MSL as the on-scene mission commander until he returned to NAS Lemoore, landing at 1104 local time. [Encl. (30)]

31. LCDR (b) (3) (A), (b) (6) USN, and LCDR (b) (3) (A), (b) (6) USN, both of VFA-151, were operating aircraft in the R-2508 complex for a different mission and heard the radio communications with Joshua Approach before proceeding overhead the mishap location to assist. LCDR (b) (3) (A), (b) (6) and LCDR (b) (3) (A), (b) (6) were on a two-ship flight conducting red air simulation in the Superior Valley restricted area R-2524. [Encls. (3), (4), (30)]

32. LCDR (b) (3) (A), (b) (6) and LCDR (b) (3) (A), (b) (6) remained overhead to continue the coordination with SAR assets until returning to NAS Lemoore at approximately 1130 local time. [Encls. (3), (4), (30)]

#### Mishap Injuries and Response

33. Seven French nationals in the United States as tourists were taking photographs in various locations along the dirt road area to the east of the Father Crowley Overlook parking lot, on the south side wall of Rainbow Canyon when the mishap aircraft impacted. The French tourists were: (b) (3) (A), (b) (6) (m/57), (b) (3) (A), (b) (6) (f/56), (b) (3) (A), (b) (6) (f/26), (b) (3) (A), (b) (6) (m/24), (b) (3) (A), (b) (6) (m/20), (b) (3) (A), (b) (6) (f/23), (b) (3) (A), (b) (6) (m/26). [Encls. (34), (36), (37), (38)]

34. (b) (3) (A), (b) (6) witnessed the mishap aircraft prior to impact as it went below the horizon of the canyon wall. Upon impact, the French tourists began to run away from the explosion, but were unable to avoid the blast. All seven French tourists suffered non-life threatening burn injuries. All were treated for burn injuries of varying degrees. All survived and have, and/or are expected to, make full recoveries. All claims and medical costs are under the purview of the Claims and Tort Litigation Director, (b) (3) (A), (b) (6) (b) (3) (A), (b) (6) at the Office of the Judge Advocate General. [Encls. (34), (36), (37), (38)]

35. The first responders on the scene included National Park Service (NPS) personnel who took a witness statement from (b) (3) (A), (b) (6) Along with other first responders, NPS assisted with medical attention for the injured French tourists and coordinated the transfer of victims to Lone Pine Hospital in Inyo County. [Encls. (34), (38)]

#### Witnesses, Reconstruction, and Recovery

36. There is no known video or photographic evidence of the mishap aircraft at the time of impact. There are no known eyewitness accounts of the mishap aircraft at the time of impact. [Encls. (24), (25), (26), (27), (40)]

37. There is video and photographic evidence of the mishap aircraft in the seconds prior to impact taken by observers positioned west of the Father Crowley Overlook area. [Encls. (24), (25), (26), (27), (40)]

38. Names of civilian observers from the mishap location include (b) (3) (A), (b) (6) (b) (3) (A), (b) (6) [Encl. (40)]

39. Based on collected photographs and video taken by observers seconds prior to impact, Naval Air Systems Command (NAVAIRSYSCOM) estimated that the mishap aircraft was travelling at 550 KCAS, approximately 4000 feet MSL, in full afterburner, and descending in a slight left-wing down profile, at or less than one-G, prior to going out of view at location N 36.357093 W 117.558178. [Encls. (24), (25), (28), (39), (40)]

40. The distance from the location when the mishap aircraft goes out of view of ground-based video to the point of impact is 3,500 US feet, or 0.58 NM. At 550 KCAS, it would take approximately 3 seconds to travel from the point where the mishap aircraft goes out of view to the point of impact. [Encls. (24), (25), (28), (39)]

41. No useable flight recorded media was recovered from the mishap aircraft, to include Deployable Flight Incident Recorder Set (DFIRS), Digital Memory Device (DMD), Removable Memory Module (RMM), or MAINT Card. Although DFIRS was recovered, NAVAIRSYSCOM efforts to access files were unsuccessful due to the extent of the damage. The DMD, RMM, and MAINT Card were not recovered. [Encls. (39), (40)]

42. Based on DMD and MAINT Card data analyzed from the wingman aircraft, GoPro video of displays which included air-to-air TACAN information, and wingman accounts, LT Walker and LT (b) (3) (A), (b) (6) stayed within approximately 2-3 nautical miles of each other for the duration of the flight. The flight overview of the wingman aircraft is known from the time of launch through the time of impact until the wingman returns to base (RTB). [Encls. (24), (26), (30), (39)]

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43. Ejection was not initiated. The Ejection Seat with catapult was properly installed in the cockpit at time of impact. The Ejection Seat Structure experienced severe ground impact damage. None of the Cartridge Actuated Device (CAD) or Propellant Actuated Device (PAD) items recovered were fired or actuated. All CAD/PAD items should have functioned as designed if actuated. No anomalies were noted to prevent ejection sequence. Aircrew restraint systems failed due to excessive crash loading. [Encl. (29)]

44. There was no toxicology report for the mishap pilot due to the lack of human remains available to conduct testing posthumously. The human remains recovered between 1 Aug and 16 Aug consisted of small amounts skin, hair, and bone. The Armed Forces Medical Examiner took custody of the human remains and determined the remains were not viable for toxicology testing. [Encl. (35)]

45. Aside from known flight events and LT Walker's leave schedule, the 72-hour summary of events prior to the mishap is largely unknown. [Encls. (3), (15), (16), (30), (31)]

46. The mishap pilot flew a similar flight profile the day before on event three of the 30 July 2019 VFA-151 flight schedule with CDR Chad Heirigs. [Encls. (28), (31), (39)]

47. On 30 July 2019, CDR Heirigs briefed an air-to-surface training mission in the R-2508 range training complex with LT Walker as his wingman. [Encls. (5), (31)]

48. Post-mission, the 30 July 2019 event three flight proceeded to the low level environment to execute the Jedi transition portion of the Sidewinder low level route prior to RTB. [Encls. (5), (28), (31)]

49. On 30 July 2019, LT Walker flew the same aircraft (BUNO 168471) with the same configuration as he did on 31 July 2019 (single centerline, outboard pylons only, ATFLIR, no ordnance/items). Downloaded data from the 30 Jul 2019 flight aircraft's MAINT card was processed by NAVAIRSYSCOM and showed a flight profile similar to the 31 July 2019 flight. [Encls. (5), (28), (31), (39)]

50. On 30 July 2019, LT Walker flew into Star Wars Canyon from the west and performed a ridgeline crossing over the south side wall. The ridgeline crossing occurred east of the 31 July 2019 impact location approximately 1,500 US feet east along the south side canyon wall. LT Walker crossed the ridgeline at 290 feet AGL travelling at 570 KCAS while pulling 1.6 G's. [Encls. (5), (28), (31), (39)]

51. The investigating officer flew several iterations of LT Walker's estimated 31 July 2019 flight profile in the simulator. Attempts to recover from the estimated flight profile resulted in controlled flight into terrain (CFIT) on 30 percent of the simulated runs. [Encls. (24), (28), (39)]

#### Opinions

1. LT Walker was adequately prepared, had proficient knowledge of the low level route despite a change in plan from the VR-209 low level route to the Sidewinder low level prior to the brief. [FF (3), (4), (5), (6), (8), (9), (12), (15-17), (23), (46-50)]

2. The pilot did not experience a G-induced loss of consciousness (GLOC) or an almost g-induced loss of consciousness (ALOC) based on the flight control movements and flight pattern witnessed in the observer video. [FF (24), (37), (39), (42)]

3. LT Walker did not commit suicide. Squadron personnel conveyed, and evidence suggests, that LT Walker had a desire to live and no known suicidal ideations existed. [FF (6-8), (15), (40)]
4. LT Walker entered a flight regime within which he could not safely escape given the proximity of the aircraft to the surrounding terrain. The airspeed of the aircraft was estimated to be 550 KCAS when last seen 0.58 NM from the impact location. At 550 KCAS, it would take 3 seconds to travel 0.58 NM. The aircraft was also thought to be accelerating, as it was in full afterburner descending in a slight nose down flight path angle at, or less than, one G. Attempts to recover from this specific, although estimated, flight profile in the simulator resulted in controlled flight into terrain (CFIT) on 30 percent of the runs executed. Although not scientifically rigorous, the simulator runs did illustrate that the flight profile was difficult to escape from an impending CFIT result. [FF (37), (39), (40)]
5. It is possible that LT Walker intended to fly through Star Wars canyon as most aircraft do – through the center of the canyon maneuvering to stay between and below the canyon walls until exiting to the east into the northern portion of Panamint Valley. However, evidence suggests that LT Walker intended to fly a similar flight path on 31 July 2019 as he did on 30 July 2019. On the date of the mishap he was faster, lower, and accelerating while descending prior to his attempt to cross a ridgeline that was approximately 500 feet higher than the day prior. LT Walker may have attempted to turn level through the canyon, realized his turn radius would be too great to navigate safely due to his speed and attempted a vertical pull to exit the canyon. Based on current information, we will never know what actually occurred. [FF (46), (48), (49), (50), Encls. (24)]
6. There is no evidence suggesting that LT Walker was “flat-hatting” – flying at low-altitudes for thrills. There is no evidence to suggest that he pre-coordinated with aviation enthusiast photographers on the ground for a photo opportunity. [Encls. (30), (31), (33), (39)]
7. LT Walker did not depart controlled flight in the aircraft prior to impacting the ground. His aircraft was travelling at well-above corner airspeed, at approximately 550 KCAS and accelerating. Any attempt to pull back on the stick in an effort to achieve a positive flight path angle would have reduced airspeed, however it would also have induced a positive rate of climb to clear the ridgeline. [FF (24), (37), (39), (42)]
8. LT Walker did not have poor visibility due to shadowing of terrain and therefore did not lose the ability to discern distance from terrain resulting in CFIT. At 0943 local time on 31 July 2019, the sun was at 99.77 degrees azimuth and 43.92 degrees altitude. The sky was clear and visibility was unrestricted. The photos illustrate the lack of shadowing from similar visual direction as the mishap aircraft prior to impact. [Encls. (25-27), (45)]
9. There is a potential for aircrew to be complacent when preparing to fly the Sidewinder low level route due to the relative ease of mission planning, availability, familiarity, and common use of the route by local area aircrews. [Encls. (9-11)]
10. All aircrew interviewed were forthright and honest with regard to the mishap. There was no attempt to conceal events through manipulation of their witness accounts or flight data. All interviewees were compliant and willing participants in the investigation. [Encls. (30-40)]

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11. The squadron culture promotes and complies with adherence to the rules and regulations with regard to flight operations. [Encl. (31)]

Recommendations

1. No administrative or disciplinary action is warranted in this case.
2. The findings of this investigation should be widely shared as an example of the unforgiving nature of naval aviation and the fact that a brief lapse in judgement can produce catastrophic results.

**(b) (3) (A), (b) (6)**