AIR COMBAT COMMAND **News Release**



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ACC releases Accident Investigation Board Report for F-16 Crash at Shaw AFB

LANGLEY AIR FORCE BASE, Va. - Air Combat Command released an accident investigation board report today regarding an F-16CM crash that occurred June 30, 2020, at Shaw Air Force Base, South Carolina, during which the pilot was fatally injured.

The pilot, 1st Lt. David Schmitz, 32, was assigned to the 77th Fighter Squadron. He was conducting a nighttime mission qualification training flight that would include his first ever attempts at air-to-air refueling and simulated suppression of enemy air defenses. After being unsuccessful at air-to-air refueling Lt. Schmitz and his flight leader had to forego the rest of the mission, based on fuel, and return to Shaw AFB earlier than planned.

During the final approach to landing, Lt. Schmitz's aircraft struck the localizer antenna array short of the runway threshold, severely damaging the left main landing gear. The aircraft briefly touched down and executed a go-around. Based on the damage to the aircraft and the anticipated directional control problems that would occur during any subsequent landing, it was decided to attempt an approach-end cable arrestment. However, the aircraft's tail hook did not catch the cable, and because the left main landing gear was damaged the left wing contacted the runway. The pilot ejected from the aircraft, but an ejection seat malfunction resulted in his parachute never deploying. Lt Schmitz impacted the ground while still in the seat and died instantly.

"This accident is a tragic reminder of the inherent risks of fighter aviation and our critical oversight responsibilities required for successful execution," said Gen. Mark Kelly, commander of Air Combat Command. "The AIB report identified a sequence of key execution anomalies and material failures that resulted in this mishap. For example, in order to account for the increased demands and pilot workload involved with night flying, Air Force Instructions mandate pilots demonstrate proficiency in events like aerial refueling in the daytime before attempting them at night. That didn't occur for this officer, and when we have oversight breakdowns or failures of critical egress systems, it is imperative that we fully understand what transpired, meticulously evaluate risk, and ensure timely and effective mitigations are in place to reduce or eliminate future mishaps."

The AIB determined the cause of the mishap was the pilot's failure to correctly interpret the approach lighting system and identify the runway threshold during his first landing attempt, which resulted in a severely damaged landing gear. Additionally, the AIB president found two factors substantially contributed to the mishap: (a) the Supervisor of Flying chose not to consult the aircraft manufacturer, which resulted in the decision to attempt a cable arrestment in lieu of a controlled ejection and (b) a series of ejection seat malfunctions occurred, which resulted in the pilot impacting the ground while still in the ejection seat.

The cost of damages to government property was \$25,016,107.

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