

# FEEDBACK

【 航空安全情報自発報告制度（VOICES）共有情報 】 一部英訳版



No. 2025-02

Dec.24<sup>th</sup>, 2025

Voluntary and Confidential Incident Reporting System (VOICES) is a safety information reporting system that was launched in fiscal year 2014 as part of the Aviation Safety Program. Its purpose is to collect information on events that may have posed safety concerns—such as so-called "near-miss" incidents—which cannot be fully captured through the Mandatory Reporting System for accidents and incidents. This information is utilized to enhance aviation safety. Some of the reported events, which have been analyzed by a team of experts, are regularly shared as part of the publication titled *FEEDBACK*.

(FEEDBACK No.2025-02-13)

## *Ground staff approached the aircraft after the interphone disconnect*

During departure from Shanghai Pudong Airport, we pushed back to L15 and initiated the engine start sequence. After all engines had been started, we instructed the ground staff to disconnect the headset. Once we visually confirmed that the ground personnel had moved away from the aircraft, we flashed the runway turnoff light as a signal. Before commencing taxi, [PACK 2] EICAS message appeared. We informed ATC that we needed to hold position and performed the required checklist. As the checklist takes approximately five minutes to complete, our attention was concentrated on the timer and the progress of the procedure. After the message cleared, we requested taxi again and received taxi clearance from ATC. However, immediately afterward, the controller cancelled the clearance and instructed us to hold position, advising that ground personnel were standing in front of the aircraft. At this point, the taxi light was already on. Shortly thereafter, a ground staff member called us via interphone to ask whether there was any problem. Recognizing the significant risk involved, we immediately instructed the individual to move away from the aircraft. We had not used any aircraft lights or the company frequency to call the ground staff back during the troubleshooting. After confirming that all ground personnel were once again safely clear of the aircraft, we signaled with the light and then continued taxi without further issues. In this event, the controller's situational awareness prevented a potentially serious accident. Once engine start has been completed and the headset has been disconnected, it is extremely dangerous—especially at night—for ground personnel to approach a large jet with its taxi light illuminated. We appreciate ATC's awareness and prompt action, and we believe that appropriate measures should be implemented to prevent a recurrence of such a situation.

(FEEDBACK No.2025-02-35)

## *Flap Retraction Below ACC Height*

While operating an Airbus aircraft departing from John F. Kennedy Airport Runway 22R with THR TOGA CONF 1B+F, we had set the ACC Height to 3,000 ft AGL for ATC monitoring considerations. At approximately 150 ft AGL, the autopilot was engaged, and HDG 224° was selected (pull) to comply with the "FLY RWY HDG" instruction. Because the departure path extended over the water, we aimed for a smooth and cautious rotation. As a result, the aircraft accelerated more than anticipated after liftoff, possibly due to wind variations, eventually exceeding S speed and approaching the Flap Placard Speed. Despite having set the ACC Height to 3,000 ft AGL, I instinctively called for FLAPS 0 (UP). At 1,500 ft

AGL, I then mechanically selected CLB THR almost automatically, which caused the airspeed to decrease rapidly. I hesitated—uncertain whether I should return to FLAPS 1, and whether doing so would correctly re-establish FLAPS 1B. While remaining at FLAPS 0, I set the thrust back to TOGA but soon recognized that the airspeed had decayed below VLS. At that moment, my awareness of the FMA modes was inadequate. I was unsure whether selecting speed might trigger an unintended mode transition or behave similarly to a speed selection following a go-around. These doubts delayed my response. Ultimately, with the timely assertion and support from the captain seated in the observer's seat during this multi-crew operation, I gained confidence to select a speed of 220 kt, which allowed us to recover the airspeed (👉).

☞ **VOICES Comment:**

✓ When Flap 1 is selected for takeoff, the Airbus flight control system enters the 1+F configuration. During the climb, if the airspeed increases and approaches VFE, the system automatically retracts the flaps—while keeping the slats extended—to protect the aircraft from flap overspeed.

(FEEDBACK No.2025-02-54)

**TCAS TA triggered by a VFR aircraft**

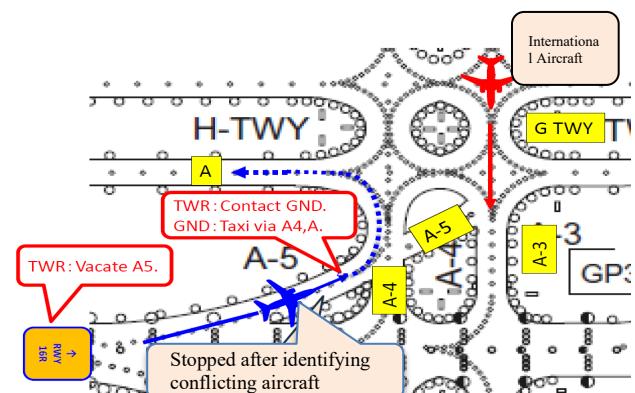
While conducting an approach to Itami Airport from the southwest, we received the clearance “CLR HABIK ARR,” followed by “Cleared for ILS RWY 32L, circle to RWY 32R.” Around 4,500 ft between HABIK and IKOMA, we detected an approaching VFR aircraft. At the time we became aware of the traffic, it was flying approximately 500 ft above us and about 5 NM to the northeast. Almost simultaneously, ATC instructed us, “Due to VFR, fly heading 010.” We subsequently requested heading 350 and received a new approach clearance. Both aircraft were descending, and at the point of closest proximity, the vertical separation had reduced to approximately 300 ft, with lateral separation of about 2–3 NM. During this time, a TCAS TA was generated, although no RA occurred. The VFR aircraft was not visually acquired. According to Kansai Approach, the traffic was identified only as “VFR traffic, unknown.” Later, we heard from other crews that certain VFR pilots departing Yao (RJOY) toward the east do not tune in to the TCA frequency, reportedly because they wish to avoid communication with ATC and potential altitude restrictions. This practice—avoiding altitude restrictions by intentionally not monitoring the TCA frequency—undermines the very purpose of maintaining safe vertical separation. I strongly believe that it is essential to continue emphasizing the importance of proper communication with the TCA for the sake of aviation safety.

(FEEDBACK No.2025-02-69)

**ATC instructions after vacating the runway**

We planned to vacate RWY 16R via A5 at Haneda Airport and landed accordingly. During the landing roll, the only instruction we received was “Vacate A5.” As we attempted to exit at A5, the PIC in the left seat (PM) identified an international aircraft on Taxiway G proceeding at high speed toward A3. We brought our aircraft to a complete stop near the A5 hold-short line (👉).

Subsequently, ATC instructed us to “Contact Ground,” and Ground Control then issued “A4, A.” Had we continued straight through A5 based solely on the initial instruction, there would have been a very high risk of a head-on conflict with the aircraft on Taxiway G. From a safety standpoint, it would have been preferable for ATC to provide an instruction such as “A5, then A4,” or alternatively to hold the traffic on G at W to ensure safer taxi flow.



(FEEDBACK No.2025-02-91)

### ***Unauthorized bus entry into the arrival stand***

After arriving at New Chitose Airport during nighttime operations, we identified the stand's VDGs and the wing-walker and then switched the exterior lights off. When we aligned the aircraft with the stand, we noticed a bus entering from directly ahead, which prompted us to make an immediate stop (👉). Even from a distance, it appeared that the bus had proceeded as far as the vicinity of the stop line. The bus then seemed to recognize our presence, stopped, and reversed back to the designated vehicle roadway. Although there was still some distance between us and an actual collision did not appear imminent, the situation could easily have developed into a serious incident had circumstances been only slightly different. At the same time, an aircraft at the adjacent stand had begun its pushback. Because we came to an unexpected stop, ATC may have been concerned about maintaining proper separation and subsequently provided us with information regarding the pushback aircraft. After parking, we asked the maintenance staff about the situation. They told us that the bus entered so suddenly that they had no opportunity to intervene. Our view from the cockpit was the same—we perceived the bus approaching at a comparatively high speed. This event reinforced the need to emphasize and re-communicate the hazards associated with ground vehicle operations in the vicinity of aircraft.

(FEEDBACK No.2025-02-94)

### ***Overshoot at Spot In***

While taxiing into the stand, I initially brought the aircraft to a stop in response to the marshaller's "Stop" signal. However, although the marshaller continued to display the same "Stop" signal, I observed a back-and-forth motion of the paddles, which led me to believe that I might have stopped short of the intended position. Interpreting this as a cue to move forward, I slightly released the brakes, and because the same ambiguous motion persisted, the aircraft continued to roll for a short distance. Recognizing the potential hazard, I promptly reapplied the brakes and brought the aircraft to a complete stop. Consequently, we came to rest well beyond the designated stop line. In retrospect, I should have halted immediately once the signal became unclear. To prevent recurrence, I will ensure that whenever instructions appear ambiguous or uncertain, I will first bring the aircraft to a full stop, confirm the situation, and always maintain a safety-first attitude.