



Australian Government

Australian Transport Safety Bureau

Taxiing conflict involving Airbus A320, VH-VFX, and Bombardier DHC-8, VH-48N

Sydney Airport, New South Wales, on 25 August 2026



ATSB Transport Safety Report

Aviation Occurrence Investigation

AO-2026-092

Preliminary – 26 October 2026

Cover photo: CCTV footage from Sydney Airport, annotated by ATSB

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Preliminary report

The ATSB has released this preliminary report to provide a timely update on evidence gathered and investigation activities to date. It outlines areas of further investigation but does not contain analysis or findings, which will be detailed in a final report at the conclusion of the investigation. The information in this report is released in accordance with section 25 of the *Transport Safety Investigation Act 2003*.

The occurrence

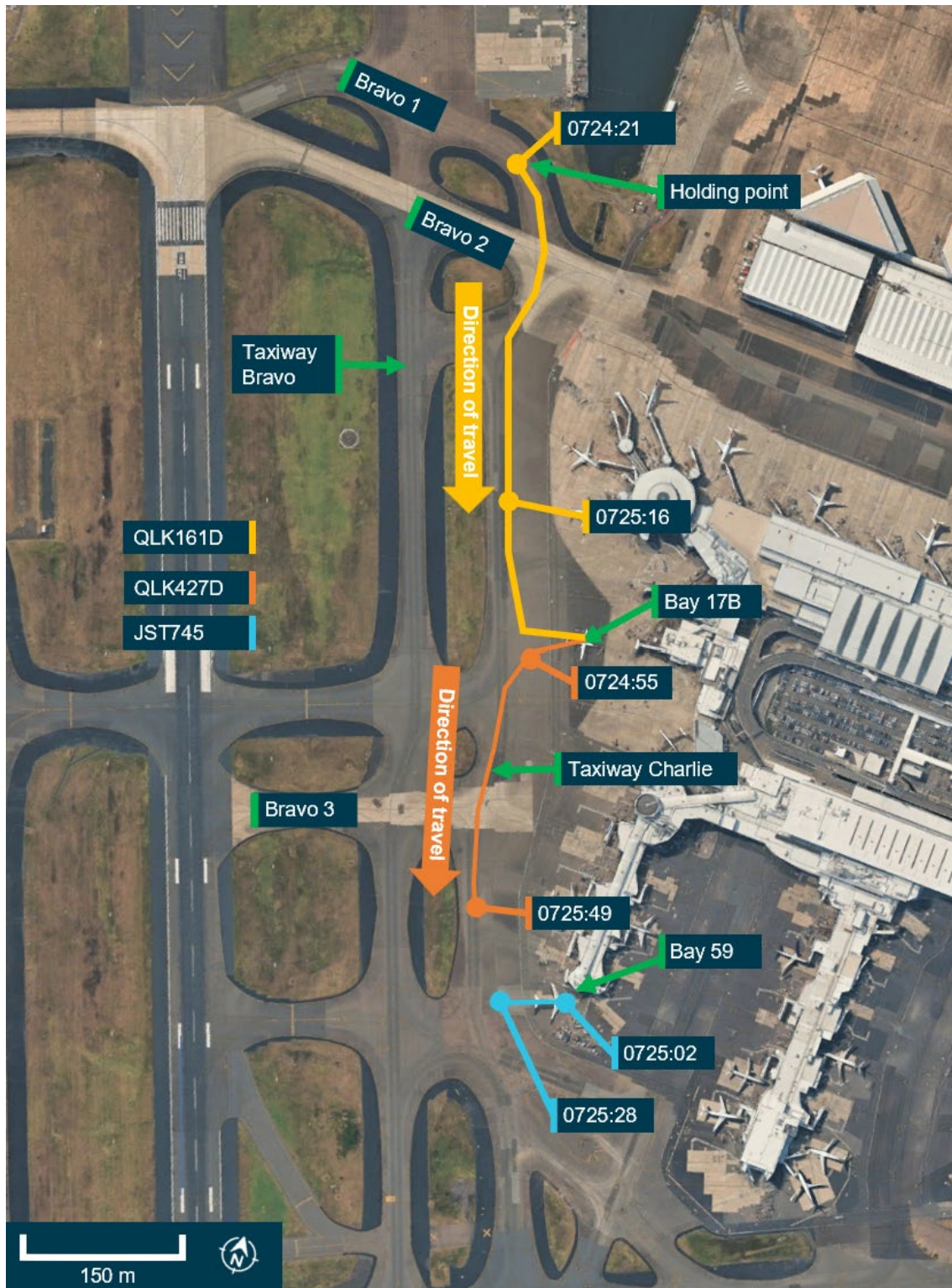
On the morning of 25 August 2026, a Jetstar Airbus A320, registered VH-VFX and operating as JST745, was preparing to push back from bay 59 onto taxiway Charlie (C) at Sydney Airport, New South Wales (Figure 1).

At 0723:46 local time the surface movement controller (SMC) cleared the flight crew to push back after giving way to another Jetstar A320 (JST402) taxiing behind them.

About 30 seconds later, the same controller cleared the crew of a Qantas Link Bombardier DHC-8, registered VH-84N and operating as QLK427D, to taxi and hold short of taxiway Golf (G) from its position at bay 17B. This required a 180° right turn to exit the bay, followed by a 90° left turn, to align the aircraft with taxiway C, facing south.

The departure of QLK427D from bay 17B allowed the controller to clear another Qantas Link DHC-8 (QLK161D), which had recently arrived and was holding short of Bravo 2, to taxi towards bay 17B.

Figure 1: Aircraft taxiing routes



Source: Google Earth annotated by the ATSB

At 0725:02, after JST402 passed behind it, JST745 commenced pushback onto taxiway C.

By this time, QLK427D had commenced taxiing, and as the captain was aligning the aircraft with taxiway C to head south, they noted the tail of JST745 seemed to be 'a long way off the bay'. As it appeared stationary at the time, the captain thought it was possible

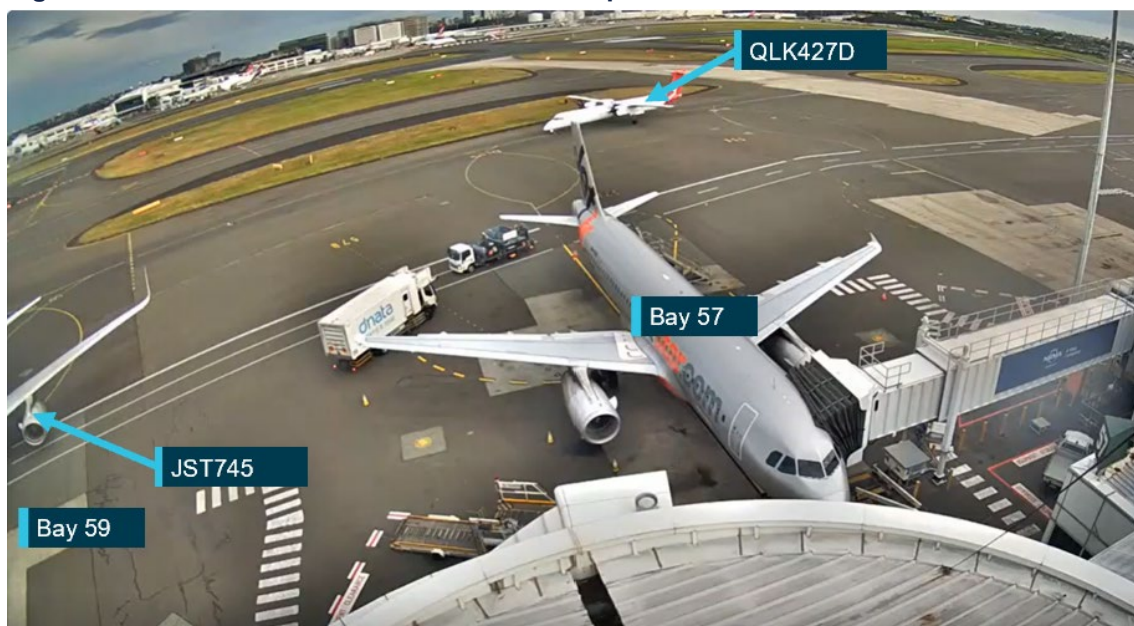
the aircraft was entering the bay and waiting for the nose-in guidance system¹ before moving forward. The captain then noted the tail was moving backwards. The crew recalled their own speed to be around 10 kt, prior to stopping their aircraft approximately 100 m from bay 59.

The pushback driver and dispatcher² of JST745 both observed the approaching DHC-8 (QLK427D), stopped the A320's pushback and advised the flight crew of the conflict.

At around the same time, the crew of QLK427D queried the controller, and a few seconds later, the crew of JST745 also queried the controller.

Closed-circuit television (CCTV) footage was provided by Sydney Airport from cameras directed towards bay 57 and captured the position of both JST745 and QLK427D during the occurrence (Figure 2).

Figure 2: QLK427D and JST745 at their closest point



Source: Sydney Airport

The controller instructed JST745 to tow back onto the bay while QLK427D passed behind, before JST745 was again cleared for pushback.

Context

Aircraft information

DHC-8 (VH-84N)

VH-84N was manufactured in Canada in 2014 and issued serial number 4483. It was first registered in Australia in August 2025, and the registered operator was Sunstate Airlines. It was powered by 2 Pratt & Whitney PW150A turboprop engines.

¹ Nose-in guidance system: an automated system may provide centreline guidance or stop position information, or both.

² Ground handling dispatcher: walks out with the aircraft, communicating with the pilot via a headset plugged in directly to the aircraft's internal communication system, to advise when to set/release breaks and when the aircraft is disconnected from the tug.

A320 (VH-VFX)

VH-VFX was manufactured in France in 2013 and issued serial number 5871. It was first registered in Australia in November 2013, and the registered operator was Jetstar Airways. It was powered by 2 International Aero V2527-A5 turbofan engines.

Flight crew information

DHC-8 (VH-84N) crew

The captain held an Air Transport Pilot Licence (Aeroplane) and a class 1 aviation medical certificate. They had accrued approximately 7,200 flight hours, with 3,270 of those on the DHC-8.

The first officer held a Commercial Pilot Licence (Aeroplane) and a class 1 aviation medical certificate. They had accrued approximately 5,078 flight hours, with 1,112 of those on the DHC-8.

A320 crew

The captain held an Air Transport Pilot Licence (Aeroplane) and a class 1 aviation medical certificate. They had accrued approximately 6,420 flight hours, with 3,030 of those on the A320.

The first officer held a Commercial Pilot Licence (Aeroplane) and a class 1 aviation medical certificate. They had accrued approximately 624 flight hours, with 356 of those on the A320.

Meteorological information

At the time of the incident, the visibility at Sydney Airport was greater than 10km. The temperature was 18° C and the wind speed was approximately 8 kt from the north-west.

Airport information

Sydney Airport has 3 runways, runway 25³/07 and parallel runways 16R/34L and 16L/34R. On the morning of the occurrence, aircraft were arriving and departing Sydney Airport using runways 34R and 34L.

Terminals 2 and 3 (Figure 3) located at the north-eastern section of the airport were used for domestic departures and arrivals and were the responsibility of the surface movement controller east (see *Surface movement control*) located in the air traffic control (ATC) tower.

³ Runway number: the number represents the magnetic heading of the runway. The runway identification may include L, R or C as required for left, right or centre.

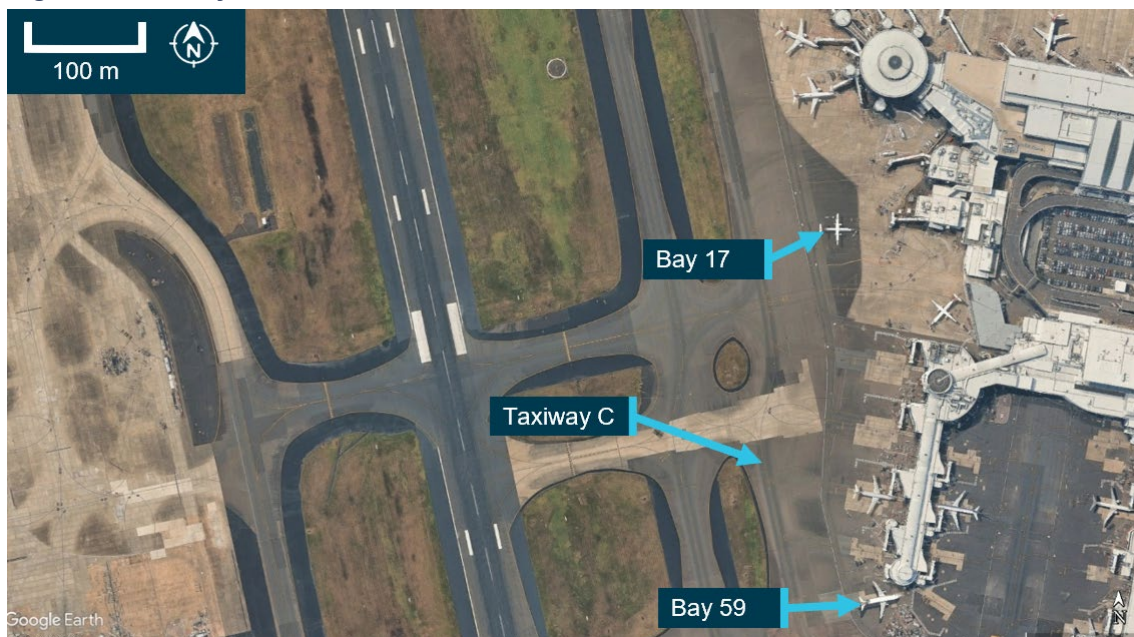
Figure 3: Terminal positions relative to tower



Source: Google Earth annotated by the ATSB

Gates 8–19 at Terminal 3 and gates 49–59 at Terminal 2 backed directly onto taxiway C (Figure 4). The 3 controllers interviewed stated that pushbacks from these gates were prone to conflicts, due to aircraft pushing back directly onto an active taxiway, rather than an apron.

Figure 4: Taxiway C



Source: Google Earth annotated by ATSB

Air traffic services

Overview

The Sydney tower had 7 designated operational positions (Table 1).

Table 1: Sydney tower operational positions

Operational position	Responsibility
Tower shift manager	General supervision of operational staff to ensure a safe and efficient air traffic service, the supervision of controllers, and the application of operational command authority.
Coordinator	The overall operation of the tower, automatic terminal information service updates, and working with external stakeholders on departure times.
Clearance delivery	Obtaining and providing airways clearances to aircraft in preparation for their departure.
Surface movement controller west	The provision of surface movement control on all manoeuvring areas and taxiways (including pushback procedures and entry/exit regulation) west of runway 16R/34L.
Surface movement controller east	The provision of surface movement control on all manoeuvring areas and taxiways (including pushback procedures and entry/exit regulation) east of runway 16R/34L, excluding taxiways controlled by Aerodrome controller east.
Aerodrome controller west	Providing traffic management to aircraft taking off and landing on runway 34L/16R.
Aerodrome controller east	Providing traffic management to aircraft taking off and landing on runway 34R/16L and management of operations on all taxiways between runway 34R/16L and taxiway C.

These positions could be combined in various ways to allow operation by fewer controllers depending on traffic state and other factors.

At the time of the occurrence, there were 6 Airservices Australia personnel occupying operational positions within the Sydney tower. This included the combined tower shift manager (TSM) and coordinator role. There were a further 2 controllers on break at the time.

There were 3 additional controllers on shift under training. They did not hold endorsements and could not occupy positions unsupervised.

Surface movement control

The Airservices *Manual of Air Traffic Services* (MATS) stated that the separation of aircraft taxiing on an airport manoeuvring area⁴ was a joint pilot and controller responsibility. It instructed that controllers should provide taxi instructions that:

- a) give adequate information to assist pilots in determining correct taxi routes and avoid collision with other aircraft or obstructions; and
- b) regulate entry to and movement on taxiways

Controllers regulated the entry and movement on taxiways by issuing limits to taxi clearances, such as an instruction to hold short of a particular taxiway intersection. Where the paths of taxiing aircraft were likely to conflict, controllers could also issue the aircraft with sequence priorities⁵ to assist them in self-separation.

⁴ Manoeuvring area: the part of an airport to be used for the take-off, landing and taxiing of aircraft, excluding aprons.

⁵ Sequence priority: control information issued to an aircraft to indicate what traffic they should give way to, and what traffic will give way to them.

Personnel information

Only positions relevant to the occurrence have been included.

Surface movement controller east

The surface movement controller east (SMCE) had been an air traffic controller for 12 years of which 5 years were in Sydney tower. They held endorsements for all control positions in the tower and were training to be a tower shift manager.

On the day of the occurrence, the controller began their shift at 0700 in the SMCE position (see Table 1). At the time of the occurrence, their roster (Table 2) had a predicted fatigue level of 'medium' (see *Fatigue risk management process*).

The controller stated that they 'felt fine' on the day, and on an alertness scale from 1 to 7, with 1 being the lowest, they stated being around a 5. However, they also stated that they felt they had 'not had many days off in the past month'.

When asked about their workload, at the time of the incident, on a scale of 1 to 10, with 1 being the lowest, they stated it was relatively low, around 3.

Table 2: Controller rostered duty times 19–25 August 2026

Date	Duty time
19 August	1250 – 2050
20 August	1250 – 2050
21 August	0800 – 1600 (course – training)
22 August	0515 – 1145
23 August	0515 – 1215
24 August	OFF
25 August	0700 – 1500

Source: Airservices Australia

Tower shift manager

The TSM had previously held endorsements and supervisor qualifications for all controller positions in the Sydney tower. However, they were returning to Sydney after a period of absence controlling at another aerodrome, and at the time of the occurrence were under the supervision of an on-the-job training instructor (OJTI) prior to their endorsements being reinstated. They began their shift at 0515, and at the time of the occurrence were operating in the combined TSM and coordinator role.

Fatigue management

Regulatory information

The Civil Aviation Safety Regulations Part 172 (Air Traffic Service Providers) Amendment (Fatigue Rules) *Manual of Standards 2023* required Airservices Australia to have a fatigue risk management system (FRMS) that was approved by the Civil Aviation Safety Authority (CASA) for implementation by 1 September 2024. Airservices Australia had submitted a draft FRMS to CASA, however the FRMS had not yet been approved. Airservices Australia had been operating under a CASA exemption since 1 September 2024 which permitted operations without an approved FRMS.

CASA reported that, while the exemption was in place, Airservices continued to operate under existing fatigue risk management arrangements and was required to meet a

number of additional conditions. This included providing CASA with regular reports on fatigue risk management and progress towards the development of an FRMS.

The current exemption commenced on 1 September 2026 and was due to expire on 28 February 2027. CASA expects Airservices to have an approved FRMS in place by the expiry of the exemption.

Fatigue risk management process

The Airservices fatigue risk management process focused on 2 controls: work scheduling, and education and awareness. Managing fatigue-related risk involved developing planned rosters/work cycles via a strategic roster planning process (which contained 12 strategic roster planning rules) and application of the tactical roster management process (risk identification, assessment and control) when changes to planned rosters/work cycles were required.

A controller could be allocated to a shift if their predicted fatigue level was flagged as 'medium' or 'high', however a formal risk assessment was required. The risk assessment considered the expected operational situation for the shift (for example, time of day and traffic volume) and applicable controls. The outcome of the risk assessment required acceptance by either a supervisor or manager, depending on the risk level.

Fatigue level predictions did not indicate that a controller was fatigued, but rather, that they were at risk of fatigue based on their roster. In addition to the organisational fatigue monitoring, Airservices required all controllers to advise their manager if they felt they were not fit for duty.

Airservices provided a list of risk controls that could be implemented to mitigate the impact of fatigue, which was managed by the tower shift manager. Some of those risk controls included extra breaks for controllers at risk, change of duties during the shift, and releasing the controllers from their duties earlier than their scheduled finish time.

Controller equipment

Flight strip board

Controllers at Sydney tower used flight progress strips (FPS) to keep track of aircraft details and position. For the SMCE controller, the FPS were moved around a flight progress board to indicate the aircraft sequence, and which aircraft were pushing back and which aircraft were taxiing. Controllers were able to mark the FPS to record specific information, such as the limit of an aircraft's taxi clearance.

The SMCE, TSM and OJTI controllers stated that there were no set procedures on how the FPS were to be moved or organised within the board. It was up to the individual controller to organise the strips in a manner which assisted them best with situation awareness.

The SMCE controller advised that it was their own methodology to bring strips into the upper section of the centre section of the board when an aircraft was cleared for pushback onto the apron, the middle part of the centre section between black dividers when aircraft were pushing back onto a taxiway, and into the lower part of the centre section of the board when an aircraft was taxiing (Figure 5).

Figure 5: Example of flight strip board (not at time of occurrence)



Source: Airservices Australia annotated by the ATSB

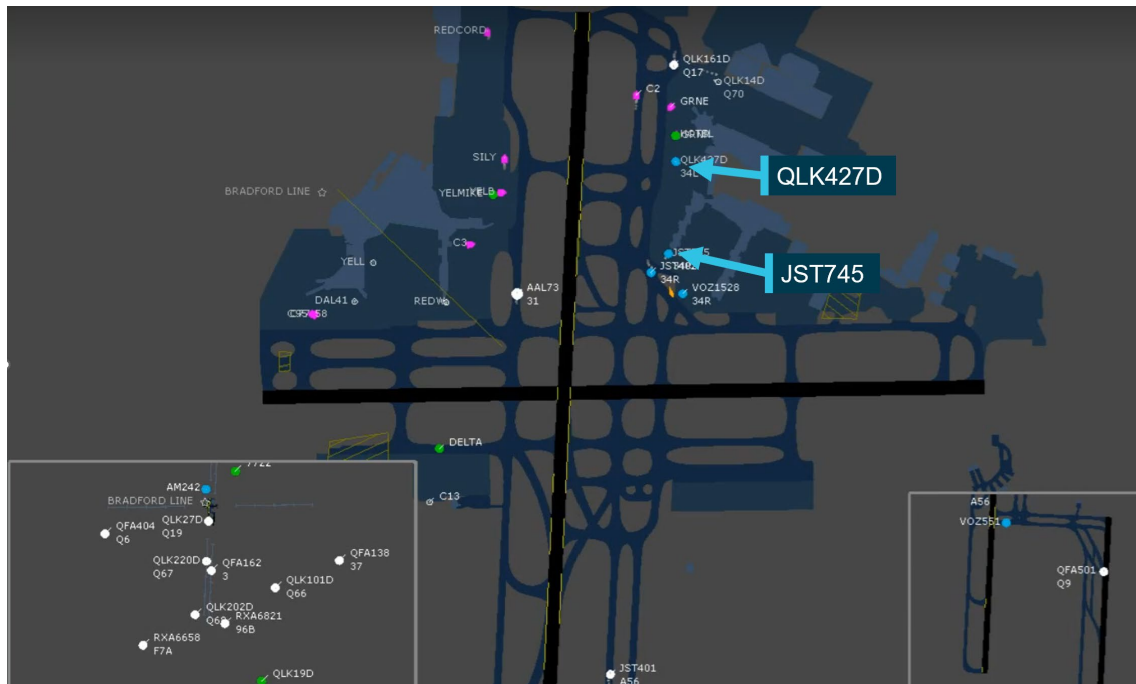
Advanced surface movement guidance and control system

The SMCE also had an advanced surface movement guidance and control system (A-SMGCS⁶) display.

Airservices A-SMGCS recordings captured the position of aircraft and ground vehicles at the time of the occurrence (Figure 6). Both the coordinator/TSM and SMCE had access to an A-SMGCS display at their controller positions in the tower.

⁶ A-SMGCS uses many distributed radio frequency sensors and surface movement radar to detect vehicles and aircraft on the airport surface. Aircraft and ground vehicles are fitted with a transponder, which transmits a signal to a receiver at the airport. Used at major airports, the A-SMGCS showed the position of aircraft and ground vehicles on a screen in front of the controller in the tower.

Figure 6: A-SMGCS screen capture at 0724:54 EST

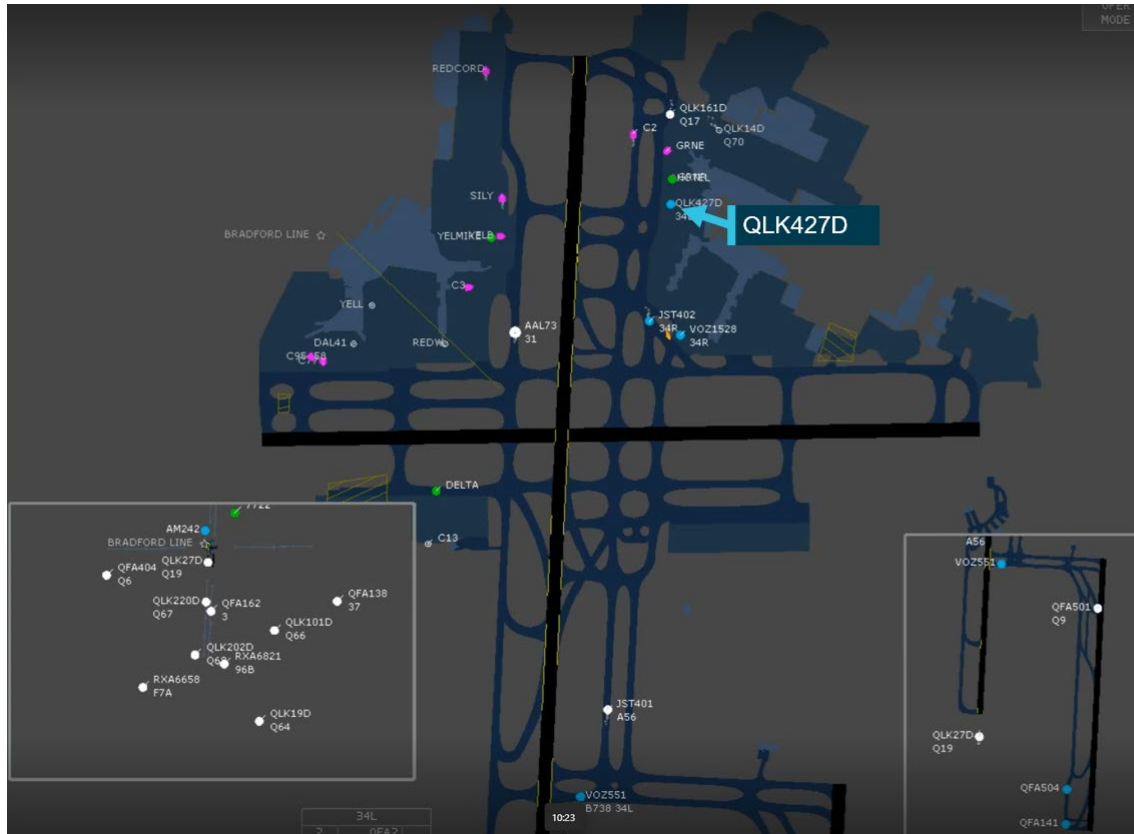


Source: Aircservices annotated by the ATSB

The A-SMGCS system did not provide alerts for aircraft taxiing conflicts on taxiways and aprons.

The TSM and OJTI reported to the ATSB that bays in that area can be a 'black spot,' as the A-SMGCS receiver did not always detect aircraft in the bays, and sometimes only displayed aircraft once they were established on the taxiway (Figure 7).

Figure 7: A-SMGCS screen shot at 0724:57 EST, with JST745 not visible



Source: Airservices annotated by the ATSB

Visibility

Multiple bays along domestic terminal 1, including Bay 17, were only partially visible to controllers for smaller aircraft, such as the DHC-8 (Figure 8).

Figure 8: View of bays 59 and 17B from SMCE position in tower



View of bay 17B from SMCE position in tower
Source: Airservices Australia

Recorded information

Aircraft data

No data was obtained by the ATSB from either aircraft.

Airservices data

Airservices provided A-SMGCS recordings and audio recordings of VHF radio communications between the SMCE and all aircraft.

Sydney Airport CCTV

Closed-circuit television (CCTV) footage was provided by Sydney Airport.

Further investigation

To date, the ATSB has:

- received Airservices advanced surface movement guidance and control system replays and air traffic control audio recordings
- interviewed the involved tower controllers and ground staff
- statements from the flight crew of both aircraft, obtained by the operators
- received manuals and procedures for Airservices
- obtained CCTV of the occurrence.

The investigation is continuing and will include:

- analysis of air traffic control data
- further review, examination and analysis of the supplied CCTV footage
- review of the visibility and systems available to controllers
- review of policy and procedures related to combined ATC positions
- review of Airservices Australia fatigue management and rostering
- review of similar occurrences.

Should a critical safety issue be identified during the course of the investigation, the ATSB will immediately notify relevant parties so appropriate and timely safety action can be taken.

A final report will be released at the conclusion of the investigation.

General details

Occurrence details

Date and time:	25 August 2026– 0728 Eastern Standard Time	
Occurrence class:	Incident	
Occurrence categories:	ANSP operational error	
Location:	Sydney Airport, New South Wales	
	Latitude: 33.9461° S	Longitude: 151.1772° E

Aircraft 1 details

Manufacturer and model:	Airbus Industrie A320-232	
Registration:	VH-VFX	
Operator:	Jetstar Airways Pty Ltd	
Serial number:	5871	
Type of operation:	Part 121 Australian air transport operations - Larger aeroplanes-Standard Part 121	
Activity	Commercial air transport-Scheduled-Domestic	
Departure:	Sydney, New South Wales	
Destination:	Launceston, Tasmania	
Persons on board:	Crew – 2	Passengers – Unknown
Injuries:	Crew – None	Passengers – None
Aircraft damage:	Nil	

Aircraft 2 details

Manufacturer and model:	Bombardier DHC-8-402	
Registration:	VH-84N	
Operator:	Sunstate Airlines Pty Ltd	
Serial number:	4483	
Type of operation:	Part 121 Australian air transport operations - Larger aeroplanes-Standard Part 121	
	Commercial air transport-Scheduled-Domestic	
Departure:	Sydney New South Wales	
Destination:	Canberra, Australian Capital Territory	
Persons on board:	Crew – 2	Passengers – Unknown
Injuries:	Crew – None	Passengers – None
Aircraft damage:	Nil	

About the ATSB

The **Australian Transport Safety Bureau** is Australia's national transport safety investigator. Established by the *Transport Safety Investigation Act 2003* (TSI Act), the ATSB is an independent statutory agency of the Australian Government and is governed by a Commission. The ATSB is entirely separate from transport regulators, policy makers and service providers.

The ATSB's function is to improve transport safety and public confidence, in aviation, marine and rail, through:

- the independent 'no blame' investigation of transport accidents and other safety occurrences
- safety data recording, analysis, and research
- influencing safety action.

The ATSB's sole focus is the prevention of future accidents and the improvement of transport safety, and prioritises investigations that have the potential to deliver the greatest public benefit.

The ATSB performs its functions in accordance with the provisions of the TSI Act and Regulations and, where applicable, international agreements.

Purpose of safety investigations

The objective of an ATSB safety investigation is to improve transport safety through:

- identifying safety issues for action by organisations with the responsibility for managing that safety risk
- influencing safety action through engaging with stakeholders, communicating findings, and fostering awareness of safety issues and concerns.

In accordance with the TSI Act, the ATSB does not investigate for the purpose of taking administrative, regulatory or criminal action, and cannot apportion blame, assist in determining liability, or, as a general rule, assist in court proceedings.

About ATSB reports

ATSB safety investigation reports are developed in accordance with ATSB procedures and guidelines, and with regard to applicable international standards and instruments.

Reports must include factual material of sufficient weight to support the investigation's analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

An explanation of ATSB terminology used in this report is available on the [ATSB website](#).