July 10, 2026
Tokyo Dome Corporation

Tokyo Dome City Attractions
Statement on Future Policies in Response to the "Flying Balloon" Accident Investigation Committee Report

On April 21 of this year, a tragic and severe accident occurred at Tokyo Dome City Attractions involving the amusement ride "Flying Balloon," resulting in the death of an employee during inspection work. We extend our deepest condolences and prayers for our late employee, and offer our heartfelt condolences and apologies to the bereaved family. Furthermore, we deeply apologize to all concerned parties and to society at large for the immense concern and inconvenience this event has caused.

Following the accident, on April 27, we established an Accident Investigation Committee composed of outside experts and specialists to conduct an objective, rigorous investigation of the facts, determine the root causes, and formulate recurrence prevention measures. Through its meetings and various associated subcommittees to date, the committee has carefully conducted investigations and deliberations. Consequently, the "Accident Investigation Committee Report" has now been compiled by the committee.

We accept the causes of the accident, the judgments of the committee, and the recurrence prevention measures presented in this report with the utmost seriousness, and we have established our future policies as outlined below.

【Accident Investigation Committee Report】

"Flying Balloon" Accident Investigation Committee Report
https://www.tokyo-dome.jp/upload/flyingballoon2026.pdf【JPN】

1. Overview of the Accident and Cause Analysis Based on the Report

On Tuesday, April 21, 2026, at approximately 11:50 AM, during a monthly inspection of the "Flying Balloon" attraction inside Tokyo Dome City Attractions, the victim of this accident — a maintenance staff member from the Technical Group of the Amusement Department (a female employee in her 20s) — was working with other Technical Group employees on the mid-section of the ride’s tower structure. Suddenly, the gondola (passenger vehicle) descended, trapping the victim between the gondola and the tower structure. Although immediate rescue operations were performed, her death was subsequently confirmed at the hospital to which she was transported.

As a result of the investigation by the Accident Investigation Committee, it was determined that the root cause of this accident was an organizational issue brought about by the vulnerability of our safety management system for employees. The overview of the accident and the cause analysis presented in this report are as follows:

<Direct Cause of the Accident and Characteristics of the Solenoid Valve>
The investigation revealed that the accident occurred while the gondola was stopped at the top, in addition to the normal monthly inspection, when the victim performed a removal and internal inspection of the "solenoid valve" located in the mid-section of the tower structure as a non-routine task not included in the original schedule or operation manual. It is concluded that upon doing so, pressure within the hydraulic circuit was released, causing the gondola to descend under its own weight.

This "solenoid valve" is a control component that regulates the ascent and descent of the gondola by switching hydraulic pressure. This task was inherently highly hazardous and should never have been attempted unless "the gondola was lowered to the very bottom and the hydraulic pressure was completely bled out."

<Background Leading to the Solenoid Valve Removal Work>
The starting point that led to this non-routine work was the confirmation on December 1, 2025, of a malfunction where the gondola's descent range was larger than usual, although it did not hinder commercial operation. During the annual inspection the following day, December 2, a representative from the construction company resolved this issue by taking measures such as removing the solenoid valve for an internal inspection while the gondola was lowered.

Subsequently, 10 days prior to the accident, on April 11, a similar malfunction occurred. Although this malfunction did not recur during subsequent test runs and presented no operational obstacles, out of an abundance of caution, an inquiry was made to the construction company. As a result, the same internal inspection of the solenoid valve as in December was suggested. In response, the victim, who was the person in charge of the attraction, planned and executed the confirmation work to coincide with the timing of the monthly inspection on April 21.

This non-routine work was not properly recognized within the Technical Group beforehand. Furthermore, its associated hazards remained unrecognized among the other Technical Group employees who were performing the monthly inspection that day.

<Root Cause of the Accident>
The primary cause of this accident was determined to be the vulnerability of our safety management system. Specifically, due to ambiguities in the scope of individual discretion and a lack of operation manuals and technical training, the organization's safety risk evaluation for hazardous non-routine work failed to function. Furthermore, the organization did not correctly recognize that the victim would be performing work on the solenoid valve and failed to verify the details of the work in advance. Consequently, this led to a situation where the victim carried out this task alone.

We feel a profound sense of responsibility for these organizational deficiencies in our safety management system, as we failed to proactively recognize the inherent safety risks of this non-routine work as an organization and failed to establish a checking mechanism to deter hazardous non-routine work.

2. Measures to Prevent Recurrence

Based on the lessons and reflections from the 2011 "Spinning Coaster Maihime" accident, the Tokyo Dome Group formulated a Safety Principle and Basic Safety Policy, established the Safety Promotion Office (currently the Risk Management Department), instituted a system where the President serves as the Chief Safety-Management Officer, and enhanced our employee training framework. Within the Amusement Department as well, we established the Education & Safety Group and the Technical Group, formulated the "Attractions Comprehensive Safety Standards" incorporating objective third-party perspectives, and established regulations and manuals related to the operation of amusement rides. Through these efforts, we have constructed and implemented a safety management system that prioritizes the “customer safety and peace of mind” above all else.

However, the recent report by the Accident Investigation Committee pointed out a fundamental issue in our safety management system: although our previous framework had consistently prioritized customer safety, it had not addressed the pursuit of “employee safety management” during operations in detail.

While maintaining the safety management foundations we have built so far, we will immediately and systematically implement the following recurrence prevention measures to rebuild a framework ensuring "an environment where employees can work with safety and peace of mind."

(1) Actions to be Implemented Prior to Resuming Operations at Tokyo Dome City Attractions

① Thorough Identification of Safety Risks During Work on All Attractions and Confirmation of Countermeasures

It was cited as an issue that the identification of safety risks during non-routine work was insufficient in this accident.

To ensure the absolute safety management of employees, we will conduct an exhaustive identification of safety risks for all amusement rides we operate and confirm that countermeasures are established and implemented, allowing employees to work securely.

[Specific Implementation Items]

- We will have manufacturers and construction companies re-verify our inspection manuals regarding amusement rides to identify safety risks.
- We will re-conduct explanatory meetings led by manufacturers and construction companies on the maintenance of each attraction, which all Technical Group members will be required to attend.
- Through these actions, we will extract tasks involving safety risks, update the inspection manuals, and have them confirmed again by the manufacturers and construction companies.

② Establishment of Clear Work Divisions with Construction Companies for Non-Routine Work

In non-routine operations involving amusement rides, it was confirmed that, in this incident, differences in understanding arose from the contractor's proposals, resulting in ambiguity about where responsibility for the work lay.

Accordingly, we will implement the following measures:

[Specific Implementation Items]
- We will extract the history of non-routine work over the past 5 years, conduct safety risk evaluations involving external experts, and identify tasks that require changes in work methods.
- Furthermore, we will clearly delineate tasks performed by our company and those entrusted to manufacturers/construction companies to clarify the boundaries of responsibility.
- If non-routine work is to be performed for the first time in the future, we will receive the work procedures via email or in writing from the manufacturer/construction company to ensure flawless communication regarding risks and important matters.

③ Establishment of Safety Risk Evaluation Systems and Procedures for Non-Routine Work

The issue in this accident was pointed out to be that it led to a situation where the victim carried out hazardous non-routine work alone without organizational safety confirmation.

Accordingly, we will implement the following measures:

[Specific Implementation Items]
- When undertaking non-routine work, a strict superior approval flow utilizing a "Prior Application Form for Non-Routine Work" (which clearly states the work details, personnel in charge, etc.) will be mandatory.
- The "Prior Application Form for Non-Routine Work" will include a checklist for safety risk evaluation to standardize the judgment of whether the work can be performed safely.
- Through this, we will systematically build an organizational safety risk evaluation system for cases where non-routine work not covered by manuals is conducted.

④ Mandatory Pre-Work Meetings

In this accident, it was determined that one of the causes was the failure to correctly share the non-routine work within the team.

By implementing the following measures, we will build a mechanism where Technical Group employees mutually share planned work details and fulfill safety-checking functions.

[Specific Implementation Items]
- To ensure reliable team-based safety confirmation for the work, we will mandate "KY (Kiken Yochi / Hazard Prediction) Meetings" prior to starting work to reliably share and check the daily work plans among members.
- Specifically, we will require staff to mutually confirm safety during work using checklists and manuals, strictly conduct work handovers even when shift changes occur, and make this a mandatory prerequisite before commencing work.

⑤ Re-confirmation of Safety During Commercial Operation

In light of this accident, we will comprehensively re-verify each amusement ride to ensure there are no deficiencies regarding the safety and peace of mind of our customers during commercial operations. Concurrently, we will re-conduct inspections of all rides, operational driving by operators, and safety training.

[Specific Implementation Items]

- We will review the operation manuals for each attraction and revise necessary sections. Additionally, we will conduct manual dissemination, education, and operational training for all employees and part-time staff involved in commercial operations.
- We will compile these implementation items—including the approval flow for non-routine work, KY meetings, absolute prohibitions during maintenance work, and categorized potential risks—into a newly revised "Basic Manual" (which previously focused mainly on basic operational procedures). All staff will be required to confirm and strictly comply with this manual prior to the resumption of operations.

(2) Matters to be Studied and Implemented Systematically and Continuously

① Strengthening of Safety Risk Evaluation Systems Upon Introducing New Attractions

Since the organization failed to share the safety risks that led to this accident, for newly introduced amusement rides, our company will deeply understand their structures and technical risks upon introduction. We will construct and operationalize a system to reflect these findings in workplace safety during operation, maintenance, and repairs.

② Establishment of Appointment and Education Systems for Technical Group Personnel

It was pointed out that within the current Amusement Department Technical Group, there are variations in hazard awareness regarding interventions into the structural components of amusement rides.

To enhance the technical capabilities of all Technical Group employees, we will clearly define the required knowledge and technical skills. We will promptly establish and implement a training program that incorporates Off-JT (Off-the-Job Training) alongside on-site OJT. Furthermore, we will clarify the scope of discretion each employee can exercise and consider establishing an internal qualification system as necessary.

③ Cultural Reform of the Technical Group

While the personnel structure of the Technical Group is fixed due to the nature of the work and teamwork was good, it was pointed out that there was a culture permitting actions dependent on individual experience and knowledge.

To eradicate this culture, we will ensure the correct understanding that safety is established by strictly adhering to regulations and rules. We will fundamentally reform the mindset to

make safety risks the highest priority consideration and to absolutely forbid any action where safety is not guaranteed.

④ Company-wide Support

It was pointed out that the company failed to grasp the various issues faced by the Amusement Department and the Technical Group and did not provide necessary guidance and support. We will not treat this accident solely as an issue for the Technical Group or the Amusement Department; instead, management will take the lead, and the entire company will unite to comprehensively enhance safety.

3. Future Outlook

(1) Regarding the Amusement Ride in Question

Following the completion of the cause-investigation process by the Committee, and with the understanding and approval of the police authorities and other related parties, the "Flying Balloon" attraction is scheduled to be dismantled and removed.

(2) Regarding the Resumption of Operations

Regarding the resumption of operations at Tokyo Dome City Attractions, attractions will reopen sequentially starting from August or later, following internal and external audits, beginning with those attractions where the steady implementation of recurrence prevention measures based on the report’s recommendations has been verified. Details will be announced on our official website as soon as they are determined.

(3) Audit and Follow-up System

We will maintain strict monitoring through internal and external audit systems to ensure that the formulated recurrence prevention measures are reliably executed. Furthermore, to strictly manage the progress of these measures, we will establish a follow-up framework involving outside experts to conduct periodic verifications of the situation.

(4) Cooperation with Investigating Authorities

We will continue to cooperate fully with the ongoing investigation. If any new facts come to light through future external investigations or official inquiries, we will report them promptly.

4. Management Responsibility (Voluntary Return of Executive Compensation)

We take our management responsibility for the organizational and administrative deficiencies that led to this tragic loss of a precious employee's life with the utmost seriousness. Accordingly, executive compensation will be voluntarily returned as follows:

Position	Name	Details of Voluntary Return
Chairman, Director	Yoshikazu Kitahara	50% of monthly basic compensation for 3 months
President and Representative Director, Executive Officer	Yutaka Saito	50% of monthly basic compensation for 3 months
Executive Vice President and Representative Director, Executive Officer	Takashi Karasuda	40% of monthly basic compensation for 3 months
Senior Managing Director, Executive Officer Chief Operating Officer of Compliance & Risk Management Division	Koichiro Hisaoka	20% of monthly basic compensation for 3 months
Senior Managing Director, Executive Officer Chief of Sales and Marketing Division	Yoshikazu Oka	20% of monthly basic compensation for 3 months

From the lessons of the 2011 "Spinning Coaster Maihime" accident, in which a customer tragically lost their life, we have built a safety management system prioritizing the safety and peace of mind of our customers above all else. However, our failure to extend employee safety management during work to every detail has resulted in this current tragic situation.

Moving forward, with a firm resolve that "creating an environment where employees can work with safety and peace of mind is just as vital to the company as the safety and peace of mind of our customers," the entire company will work as one to regain trust. We deeply reaffirm that true safety and peace of mind form the unwavering foundation of our Group's existence.

Furthermore, employee safety measures are not limited to these recurrence prevention measures. If there are further measures or mechanisms that should be implemented to create an environment where employees can work with safety and peace of mind, we will exhaust all means and execute them company-wide.

To ensure that such an accident is never repeated, the entire organization will exert unremitting efforts to further cultivate and embed a culture of safety.