Australian Government
Australian Transport Safety Bureau

Stevedore fatality on board *Tasmanian Achiever*

Webb Dock, Melbourne, Victoria | 20 May 2014

Investigation

ATSB Transport Safety Report
Marine Occurrence Investigation
309-MO-2014-004
Final – 2 September 2014

Cover photo: **ATSB**

Released in accordance with section 25 of the *Transport Safety Investigation Act 2003*

Publishing information

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Addendum

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What happened

At about 0700[1] on 20 May 2014, the 184 m general cargo roll-on/roll-off ship *Tasmanian Achiever* (cover) berthed at Webb Dock, Melbourne. Cargo discharge began shortly afterwards and was completed at about 1200. Back loading of the ship's main vehicle deck began shortly afterwards.

At about 1230, loading of the after section of the weather deck began. Loading operations then moved to the forward end of the weather deck.

Figure 1: Roll trailer and tractor configuration

Source: ATSB

Three single stacked roll trailers (Figure 1) were loaded at the port forward end of the weather deck via the aft port side ramp. Each was driven into position by a rear mounted prime mover (tractor).

A stevedore was on the deck during loading, assisting with loading operations and positioning rubber mats under the steel foot of the loaded roll trailers. The stevedore carried a UHF radio which could be used to talk to the tractor driver when positioning the trailers. Three ship's crew members were also on deck assisting with lashing of the loaded trailers, as was a refrigeration mechanic who was checking loaded refrigeration containers.

As the next roll trailer was driven up the ramp to the weather deck, the stevedore picked up some mats that he needed to position on the deck. Then, as the trailer came on the deck and aligned with the next vacant slot alongside the already loaded trailers (Figure 2), the stevedore moved towards the area in which he was going to position the mats. This location was in the path of the trailer and not visible to the tractor driver.

The ship's crew members could see the stevedore moving towards them and assumed that he saw the approaching trailer. When they realised that the stevedore was in the direct path of the trailer, they attempted to warn him and the tractor driver, but their calls went unheard. The trailer then struck the stevedore and travelled about 13 m before the driver was advised of what had happened and he stopped the tractor.

The ship's master and shore management were advised of the accident and, at 1337, a call was made to 'triple zero'[2] to advise the emergency services. When the supervising stevedore arrived

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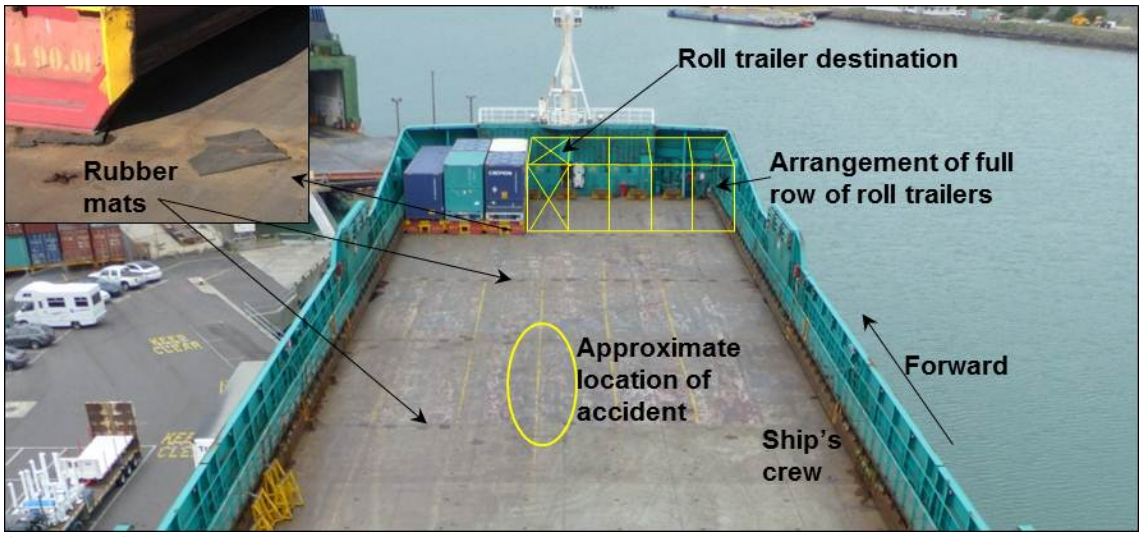
1 All times referred to in this report are local time, Coordinated Universal Time (UTC) + 10 hours

2 Triple zero (000) is the telephone number for a single point of contact for all emergency services that can be used anywhere in Australia.

on board, he provided the injured stevedore with first aid following the advice of the 'triple zero' operator.

By about 1355, paramedics and officers from the police and the fire brigade had arrived on the scene. The paramedics were unable to revive the stevedore and he died as a result of the injuries he had sustained.

Figure 2: Weather deck layout at time of accident (inset showing use of rubber mats under roll trailer foot)



Source: ATSB

Visibility limitation

It was normal for loaded roll trailers to be pushed by the tractor onto the ship for loading onto the forward end of the weather deck. In this configuration, the driver's view ahead was restricted by the containers on the trailer (Figure 3). The driving position allowed for a clear view along the left hand side of the load but almost no visibility down the right had side. The tractor was fitted a rear view mirror, but in the push configuration this mirror was positioned behind the driver and, hence, provided no assistance.

Figure 3: Tractor and driver's perspective

Source: ATSB

ATSB comment

Decisions regarding whether to conduct an investigation, and the scope of an investigation, are based on many factors, including the involvement of other safety bodies such as workplace health and safety organisations and the level of safety benefit likely to be obtained from an investigation.

In this case, Victorian Workcover Authority[3] carried out an investigation of this accident and a thorough analysis of the safety factors that contributed to it. Victorian Workcover Authority continues to work with the involved parties to ensure that effective safety actions are appropriately implemented. As a result, the ATSB only carried out a limited-scope, fact-gathering investigation in order to produce a short summary report, and allow for greater industry awareness of potential safety issues and safety actions.

Safety action

Whether or not the ATSB identifies safety issues in the course of an investigation, relevant organisations may proactively initiate safety action in order to reduce their safety risk. The ATSB has been advised of the following safety actions.

Toll Shipping

Toll Shipping has advised that, as a result of this accident, discussions with its workforce and Victorian Workcover Authority they have taken the following interim safety actions:

- a review of ship loading operations to improve control of the types and flow of cargo onto and off the ship
- placed an additional stevedore on deck to improve coordination of personnel and traffic
- provided additional radios for stevedores and ship's crew
- implemented clearly defined traffic control for vehicle entry onto deck

The company has further advised that it will continue to review these safety actions with the workforce and the Victorian Workcover Authority.

Safety message

Cargo operations on board ships are an inherently dangerous task. Therefore, it is important that hazard identification and risk analysis processes are a continual part of doing business. Known risks should be regularly reassessed in light of continued operations, experience and changing technologies to ensure the most appropriate risk controls are in place and being implemented.

The ATSB SafetyWatch highlights the broad safety concerns that come out of our investigation findings and from the occurrence data reported to us by industry. One of the current safety concerns is marine work practices www.atsb.gov.au/safetywatch/marine-work-practices.aspx.

General details

Occurrence details

Date and time:	20 May 2014 – 1337 EST	
Occurrence category:	Accident	
Primary occurrence type:	Fatality	
Location:	Webb Dock 1 East – Port Melbourne	
	Latitude: 37° 50.442' S	Longitude: 144° 54.377' E

[3] As 1 July 2014 WorkSafe Victoria changed its name to the Victorian Workcover Authority.

Vessel details

Name:	*Tasmanian Achiever*	Year built:	1999
IMO Number:	9180190	Draft (summer):	6.350 m
Flag:	Australia	Deadweight (summer):	11,000 t
Classification society:	Det Norske Veritas	Length overall:	184.4 m
Owner(s):	Commonwealth Bank Australia	Moulded breadth:	23.60 m
Manager:	Toll Shipping	Main engine(s):	4 x Wartsila 8L32

About the ATSB

The Australian Transport Safety Bureau (ATSB) is an independent Commonwealth Government statutory agency. The ATSB is governed by a Commission and is entirely separate from transport regulators, policy makers and service providers. The ATSB's function is to improve safety and public confidence in the aviation, marine and rail modes of transport through excellence in: independent investigation of transport accidents and other safety occurrences; safety data recording, analysis and research; and fostering safety awareness, knowledge and action.

The ATSB is responsible for investigating accidents and other transport safety matters involving civil aviation, marine and rail operations in Australia that fall within Commonwealth jurisdiction, as well as participating in overseas investigations involving Australian registered aircraft and ships. A primary concern is the safety of commercial transport, with particular regard to fare-paying passenger operations.

The ATSB performs its functions in accordance with the provisions of the *Transport Safety Investigation Act 2003* and Regulations and, where applicable, relevant international agreements.

The object of a safety investigation is to identify and reduce safety-related risk. ATSB investigations determine and communicate the safety factors related to the transport safety matter being investigated.

It is not a function of the ATSB to apportion blame or determine liability. At the same time, an investigation report must include factual material of sufficient weight to support the 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.

About this report

Decisions regarding whether to conduct an investigation, and the scope of an investigation, are based on many factors, including the level of safety benefit likely to be obtained from an investigation. For this occurrence, a limited-scope, fact-gathering investigation was conducted in order to produce a short summary report, and allow for greater industry awareness of potential safety issues and possible safety actions.

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