LP BULLETIN

Friday 22 August 2008

Bulletin 597 - 8/08 - Near Collision Incident - Worldwide

The Australian Transport Safety Bureau (ATSB) has published their investigation report into the near collision between a bulk carrier and ro/ro general cargo ship. Members are encouraged to consider the safety implications as summarised in this bulletin, and download the full report for review from the ATSB website.

The near collision occurred in the South Channel (The Cut) in Port Phillip, Australia, where the outbound bulk carrier passed within twenty metres of the inbound ro/ro at a combined speed of 30 knots. The ATSB investigation found that the ro/ro's bridge team members had not effectively implemented bridge resource management principles, were not keeping an adequate lookout, and had lost situational awareness. The investigation also found that the ships did not communicate with each other until after the incident.

The master on the ro/ro had forgotten that the bulk carrier was approaching and did not see the approaching ship until immediately before the ships passed. The master of the bulk carrier saw the ro/ro approaching along the centreline of the channel and took his ship further to starboard to avoid a collision. The investigation report identifies the following safety issues:

- The execution of bridge resource management on board the ro/ro was inadequate because single person errors, such as the loss of situational awareness and the failure to keep an effective lookout, went unchecked. Furthermore, both members of the bridge team operated under erroneous assumptions about their role within the team, believing that the other was keeping an effective lookout when, in fact, neither was.

- Neither the ro/ro nor the bulk carrier had adequate bridge procedures or an adequate passage plan, with respect to identifying, monitoring and managing traffic.

The ATSB made a recommendation to the ship managers that they take action to address the above safety issues.

The lack of effective radio communication between the two ships meant that the ro/ro was not alerted to the presence of the oncoming bulk carrier. By not using the radio, the bulk carrier's master did not take all available measures to reduce the risk of collision. The ATSB advises that ship owners, operators and masters consider the safety implications of this safety issue and take action where considered appropriate.

Additionally, the operating procedures for the vessel traffic service (VTS) covering the South Channel did not define any operations that had an increased level of risk and which may have required greater vigilance. Furthermore, the procedures did not define any operating limits to provide guidance for the VTS operators to determine when they should intervene. The ATSB made a recommendation to the Port of Melbourne Corporation that it takes action to address this safety issue.

Source of information: Australian Transport Safety Bureau (ATSB)
http://www.atsb.gov.au/publications/investigation_reports/2007/MAIR/mair242.aspx

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