MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 8 MARCH 2017 (NO. 2 OF 2017) IN CASE 2016.V3-NEDLLOYD BARENTSZ

As petitioned by:

the Minister of Infrastructure and the Environment in The Hague,
petitioner,
authorised representative: M. Schipper,
inspector at the Human Environment and Transport Inspectorate (ILT)/Shipping in Rotterdam,

versus

H.J. J.,
the person concerned,
counselor: J.M. de Boer.

1. The course of the proceedings

On 16 June 2016, the Maritime Disciplinary Court received a written petition for a disciplinary hearing of the case against the person concerned as the first officer of the Dutch seagoing vessel Nedlloyd Barentsz from M. Schipper, inspector ILT/Shipping in Rotterdam. Eighteen appendices were attached to the petition.

The Disciplinary Court has notified the person concerned of the petition by letter (sent both by registered and ordinary mail), enclosing a copy of the petition with appendices, and has informed the person concerned of the right of appeal.

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On 28 September 2016 a statement of defence was received from the lawyer of the person concerned.

The inspector responded to this by submitting a reply on 10 November 2016, which was followed on 19 December 2016 by a rejoinder from the lawyer of the person concerned. Copies of these documents have been forwarded to the inspector and the lawyer of the person concerned respectively.

The presiding judge stipulated that the oral hearing of the case will be held at 14.00 hours on 25 January 2017 at the offices of the Disciplinary Court in Amsterdam.
The Human Environment and Transport Inspectorate and the person concerned and his lawyer were summoned – the latter both by ordinary and registered mail – to appear at the hearing of the Disciplinary Court.

The court hearing was held on 25 January 2017. M. Schipper, inspector at the ILT/Shipping appeared at the hearing for the petitioner. The person concerned appeared, represented by his lawyer, J.M. de Boer,

2. The petition

In summarised form, the following forms the basis for the petition.
On 25 March 2015 the Dutch ship Nedlloyd Barentsz was moored in the port of Ambarli Kuport, Istanbul, Turkey, when the monorail crane jumped the mechanical end stopper on the starboard side of the rail. When the crane fell on the deck the railing was struck and fell against the seaman R. N.. The seaman spent a week in hospital with internal bleeding but eventually made a full recovery.
The person concerned was the ship's first officer at the time.

The person concerned is accused on the one hand of not sufficiently considering all relevant and available information (in particular that the limit switches would not work) in a situation in which this should have been done,

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and on the other that he – and under his authority, the boatswain and the seaman – took position virtually directly under the crane to operate it and thus acted in breach of Section 55a of the Dutch Seafarer's Act.

3. The position of the person concerned

The person concerned has argued – in summarised form – that he consulted all available information, did not take a dangerous position, and that he is not to blame for what happened.

4. The assessment of the petition

A. The following information is derived from the ship's details attached to the petition (annex 2 to the petition). The Nedlloyd Barentsz was sailing under the Dutch flag at the time. The owner was Bank of Scotland Asset Finance Limited, bareboat charterer Maersk Line U.K. Limited and manager Maersk Line A/S.

B. A "Statement of facts Nedlloyd Barentsz Monorail Failure 24 March 2015" submitted with the petition (annex 10 to the petition), drawn up by the second officer on 24 March 2015 contains – where relevant – the following information:

"On 24 March 2015 the monorail was used to discharge garbage. After discharge of garbage the monorail stopped working in outboard position. This was reported to the second engineer by the second officer. Electrician investigated and reported short circuit in the monorail power cable. Attempt was made to retrieve the monorail by lifting the brake of the travel gear. On attempting to do this it was decided to abandon this idea as it was assessed to dangerous due to the location of the travel gear motor above the quay. In consultation with the chief engineer and second engineer it was decided to make an emergency power supply to the monorail in order to retrieve the monorail back in storage position. Once the connection was made the

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monorail was operated and travelled in the wrong direction and did not stop when the operating handle was released. The mechanical end stop broke off and the monorail fell on deck. The OS (ordinary sailor) standing on the deck was hit by a railing that broke off when the monorail fell down.
The chief officer ordered the second officer to raise general alarm and PA announcement.
[..] OS was put on stretcher and taken to the hospital for treatment and investigation."

C. A copy of the "Personal Injury Investigation of Nedlloyd Barentsz" dated 7 April 2015 of Maersk Line (annex 16 to the petition) contains information including the following:

"**Final comment:**

- Investigation could not determine what caused the initial short circuit in the Power Cable [..]
- The Proximity switches were tested during the investigation and were found to function correctly;
- The signal from the proximity switch to the Programmable Logic Controller (PLC) which controls the operation monorail were found to be received but when the phase was connected incorrectly the signal from what the PLC assumed to be the irrelevant side were ignored. In other words as the crane moved in the wrong direction the proximity switch activated but because the PLC assumed the crane is moving in the direction of the control lever it disregards the signal and allows the crane to continue moving;
- The failure of the End Stopper cannot be explained at this time – it could not be examined as it was not possible to access safely;
  [..]

D. Section C. of the report referred to above contains part of the crane manual (KGW Schweriner Maschinenbau) of the Nedlloyd Barentsz, which contains – where relevant – the following information.

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"**2.4.2. Verifying the sense of rotation of the driving motors**

When resuming operation, the sense of rotation of all driving motors is to be verified.

! Attention When running in the wrong direction of rotation, the limit switches of the hoisting winch are not effective.

1. Switch on the AC motors by pressing upon the control switch on the remote control.

If the sense of rotation of the AC motors does not correspond to the driving function, interchange two external conductors in the ship's feed line to the switch cabinet.
[..}"

E. At the hearing of 25 January 2017 – rendered in summarised and concise form – the following statement was made:

"When the chief officer went to the harbour office he heard that something had gone wrong. The crane was not in the right position. He believes that the second officer told him about the incident. After that the chief officer and the captain and second officer went to see what was going on.
The chief engineer and the electrician were present at the scene. Measurements were taken. An initial plan was formulated. The chief officer was not involved in drawing up this plan. The person concerned was however informed of the plan. The second engineer, the captain and the second officer drew up this plan. The plan was to use a tackle to pull the monorail in. It then became clear that this could not be done safely, and was therefore not done.
The chief officer states that he positioned a ladder to execute the first plan together with the electrician, the boatswain and the second officer. The

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purpose of this was to release the brake. However this was unsuccessful. This was not a safe way of working.
The electrician then offered to connect an emergency power supply. The chief officer then referred to the chief engineer. The chief officer was unable to make that decision.
The chief officer states regarding the second plan that he was told that the hoisting motors could not be operated with the emergency power because it would draw too much current. This was due to the thin temporary power cable.
According to the manual the trolley would travel to the wrong side when connected. The correct phase sequence was unclear. This made it unclear which way the crane would move. This was to be established experimentally. This was discussed with all officers at the time. The chief officer was only involved in the actual operation of the crane; not the connection of the emergency power.
The boatswain had taken the remote control of the crane and operated it without the chief officer knowledge. The chief officer heard something click at the time. The chief officer was on the upper deck at the time. He then went down and asked the boatswain whether he had done something. The boatswain only said that he had tried to bring the load down. The chief officer said this was not the idea. That is why the chief officer took over the control from the boatswain. He had the most experience.
The presiding judge shows a photo of the ship from the file (page 49 petition of the chief engineer) to determine the position of the person concerned. The chief officer says that the photograph marking is completely wrong in terms of the position. The chief officer draws his position on the photo to the left of the figure. He says that the photo does not clearly show the position of him and the boatswain and seaman. They were standing against the containers. They were not under the crane. They were next to the crane, against the railing of the ship's stern. All three were standing side by side.
The presiding judge asks whether there are any rules about where to stand to operate the crane. The chief officer says that there are no such rules. That is

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left to people's own judgement. The only rule is that you must not stand under the load of a crane.
The crane's remote control was attached with a cable. The crane cannot be operated by radio signal. The cable restricts the freedom of movement. The monorail was about 16 meters long and the cable about 10 metres. The operator always stands at the crane, there is no other way. You have to take account of the height of the moving part of the monorail. You have to walk with the monorail when you operate the remote.
The chief officer says that he has operated the crane very often.
How did the chief officer use the remote control? He states that he tapped the joystick with two fingers to port. You would then usually see the crane move in that direction. He deliberately only gave a little tap to see in which direction the crane would move. If the crane went the wrong way he would still be able to get it to move the other way, which is why he gave a little tap. The joystick then returned to the middle position.
When the chief officer saw that the crane did not stop in the middle position, he tried to stop it and move it the other way. But the crane kept moving. There was nothing else notable about the rail. The brake should have been applied. That is when the crane jumped the end stopper and fell.
The crane moved at the speed expected by the chief officer. The crane moved at slow speed. Then it all went wrong. The crane fell against the railing which fell against the seaman, who has fortunately now made a fully recovery.

The chief officer did not intend to use the limit switch because the idea was to move the crane in the other direction. If the crane went the wrong way, there was still enough time to stop it. He also expected the electronic limit switch to work if necessary. The distance between limit switch and the mechanical end stopper was about 20 cm. According to the chief officer the crane was within its working area.
Mr Tromp notes that the length of the remote control cable was limited and wonders whether he could have stood on the second deck. The chief officer says that that could have been done with a degree of improvisation, but there

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was still a load in the crane and the view was less clear from the upper deck. That is why it was decided to operate the monorail from a deck lower. The chief officer, the boatswain and the seaman were standing on the right side of the platform.
The PLC can work very quickly. The brake is immediately applied if the motor is not controlled by the PLC. The chief officer had only given a cautious tap, but the crane shot through. The brake works alternately with the motor. The brake is applied if the motor is not running.
Mr Den Heijer asks the following question: Was the injured seaman involved in the repair? The chief officer says that this was not the case. He was not doing any other work. I did not give him any instructions to stay where he was. The seaman was there purely out of interest and a sense of responsibility; I had the feeling that he wanted to finish his job.
Mr Den Heijer then asks what the boatswain's role is. Was it his role to use the monorail?
The reply is that the chief officer normally operates the monorail. The electrician had said that the chief officer could finish the job with the power applied. The boatswain tried to bring the load down. The crane is usually lashed down by 2 people. There was no need for either the seaman or the boatswain to be on the same deck as the chief officer.

In response to Mr Den Heijer's question the chief officer says that an instruction to countersteer was given. He also pressed the emergency stop, but the crane was already going down. Mr Kanders asks whether there was another plan. The chief officer indicates that plan 2 was only used when it turned out that plan 1 was not possible. There was no alternative plan.

Reference is made to the notarial record of the hearing for the detailed statement of the person concerned.

F. The inspector stated at the hearing there was a convergence of circumstances that led to the accident. In retrospect, the first plan should have been carried out. It is important to the inspector that if a ship's officer

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does something different from the usual routine it is always possible for something to go wrong, and this should be taken into account.
The inspector asks the disciplinary court to rule on whether this was good seamanship. He drops his written demand at the hearing and leaves it to the disciplinary court to rule on this and to impose any necessary disciplinary measure.

5. The ruling of the Disciplinary Court

A. The Disciplinary Court concludes that the person concerned was fully aware of the risks indicated in the manual of operating the crane after connecting the temporary power cable. He also took responsibility when he took over the remote control from the boatswain. He operated it with the necessary caution. The person concerned was prepared for the crane to move to the other side, but not for the fact that it might not be possible to stop it. Nor was there any need to make allowance for the fact that the limit switches and mechanical end stoppers would not be to their task. The ship was well maintained and met all safety regulations. It is highly probable that there was a technical fault. Either way, it has not been demonstrated that the accident could have been avoided had the person concerned operated the crane differently. According to the Disciplinary Court there was no better solution available to get the crane out of its outboard position, and leaving the crane in this position was too dangerous. The Disciplinary Court does not share the (initial) charge of the inspector that he did not sufficiently consider all relevant and available information (in particular that the limit switches would not work) when this should have been done.
The same applies to the second charge regarding the position that he – and under his authority also the boatswain and the seaman – took virtually directly under the crane. Viewed in retrospect it would have been better if the first officer had taken the time to assess all conceivable risks of the operation and sent the boatswain and seaman away since their presence was not required during the operation of the crane. However, given the fact that – contrary to the charge – they were not directly under but more diagonally

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away from the load, it cannot be ruled that the person concerned acted contrary to the care expected of a good seaman in respect of the persons on board, the vessel, the cargo, the environment and shipping.

B. The Disciplinary Court dismisses the charges against the person concerned.

6. The decision

The Disciplinary Court:

- rules that the complaints against the person are unfounded.

Duly delivered by P.C. Santema, deputy presiding judge, D. Willet, C.R. Tromp, S.M. den Heijer and T.W. Kanders, members, in the presence of E.H.G. Kleingeld, as secretary and pronounced by A.N. van Zelm van Eldik in public session on 08 March 2017.

P.C. Santema
deputy presiding judge

E.G.H. Kleingeld
secretary

A.N. van Zelm van Eldik
presiding judge

E.G.H. Kleingeld
secretary

An appeal against this ruling can be lodged within six weeks of the date of forwarding with the Dutch Trade and Industry Appeals Tribunal ('College van Beroep voor het Bedrijfsleven'), Prins Clauslaan 60, 2595 AJ The Hague, P.O. Box 20021, 2500 EA The Hague, the Netherlands.

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