

**RULING OF THE MARITIME DISCIPLINARY COURT OF THE
NETHERLANDS
OF 8 MARCH 2017 (NO. 3 OF 2017)
IN CASE 2016.V4-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

P.W.L. P.,
the person concerned,
counsellor: 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 Chief Engineer 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.



On 28 September 2016 a statement of defence was received from the counsellor 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 counsellor of the person concerned. Copies of these documents have been forwarded to the inspector and the counsellor 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 counsellor 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 counsellor, 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 chief engineer at the time.

The person concerned is accused 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, 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 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 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.

“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:

“The chief engineer was asked what happened that afternoon. He stated that he was working with the electrician on the main engine maintenance. At a given point in time the monorail was not receiving any power. It turned out that there had been a short circuit between 2 phases of the supply cable. The second engineer and the electrician removed the fuse. The cabling was then measured upwards towards the monorail. The only way to do this was to use a tackle to pull the monorail into the rail. The engineering department was called out at that time. They were to rig the tackles. The brakes of the travel motor were to be released. He and the electrician then checked the manual. The manual did not explain how the crane was to be moved in this situation. The brakes had to be released. The whole cover had to be taken off.

But the emergency procedure was not mentioned in the manual. A large part of the manual had already been viewed. This was done again afterwards. Most of the attention was initially paid to releasing the brake. After that they went below again. After that the chief engineer continued with the surveyor.



The chief engineer states that he later offered to temporarily replace the defective power cable. The chief engineer consulted the manual a second time. There was a discussion about where to place the cable.

The second plan was discussed with all the officers. According to the manual the trolley would travel to the wrong side when connected. That was recognised and everybody knew this.

The electrician was the technical person who was to connect the temporary supply cable. The chief engineer then went with the surveyor to the engine room. He heard whilst there that the monorail had fallen down.

The deck was cordoned off and attempts were made to save the situation. The seaman had already been struck. This all happened very quickly.

Mr Willet asks: what is the impression of the chief engineer regarding this crane's sensitivity to maintenance? In other words, had the crane been properly maintained?

The chief engineer: it is true that maintenance has been performed correctly. The crane is however sensitive to faults.

The distance from the trolley to the limit switch was about 50 to 100 centimetres. The distance from the limit switch to the end stopper was about 10–20 cm.

The mechanical end stopper was not sufficient to hold the crane. It should in principle have been sufficient. The limit can have a little slack. The chief engineer says that something went wrong during execution. The end stopper should have held. It was not the intention for the crane to continue.

The alternative power supply was connected to the crane by the electrician on the instructions of the chief engineer. But the chief engineer did not check this. The chief engineer had gone below at the time.

Mr Tromp asks about the reverse period of the electrical motor: what happens if you put the handle on the other side? The brake was not activated. The answer given to the disciplinary court by the chief engineer is that the travelling motor (which is much smaller than the lifting motor) is controlled by the PLC.



The PLC can work very quickly. The brake is immediately applied if the motor is not controlled by the PLC.

The chief engineer indicates that everything stops as soon as the joystick is in the middle position.

Mr Den Heijer asks whether the chief engineer regards it as being logical that the limit switch on the side where the crane is not sent is deactivated.

The chief engineer explains that the limit switch only stops the motor in the corresponding direction. The opposite direction remains operational. If the rotation of the motor is wrong, and therefore also the direction of travel, the working limit switch is of course never reached because it is on the wrong side (which means that the wrong movement direction is turned off).

Mr Willet asks why the controls did not work. The chief engineer explains that the control cable was crushed, but that this was discovered after the fall. The electrician had shortened it before switching on after resetting the crane, which could be why the control fault could not be reproduced.

The limits were tested. It is difficult to establish the cause of the accident.

The presiding judge asks whether the people concerned were under pressure that afternoon.

The chief engineer indicates that there was pressure from the quayside to get the monorail beam in. But that was no reason to do this quickly. The planning was correct, but the execution went wrong. The end stopper should in fact have held, which would have prevented this from happening.

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 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

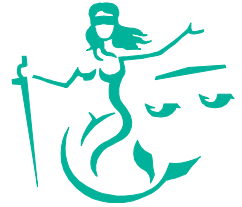
A. The Disciplinary Court concludes that the person concerned was fully aware of the risks indicated in the manual of operating the crane after connecting the temporary power cable. He shared this information with others, including the first officer, who operated the crane after the power cable was connected. He was prepared for the crane to move on 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 up 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 crane been differently operated. 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 the person concerned did not sufficiently consider all relevant and available information (in particular that the limit switches would not work) when this should have been done. Therefore, 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.